Exceptional CHILDREN

JOURNAL OF THE INTERNATIONAL COUNCIL FOR EXCEPTIONAL CHILDREN

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Exceptional CHILDREN

JOURNAL OF THE INTERNATIONAL COUNCIL FOR EXCEPTIONAL CHILDREN

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Merry Christmas

and a

Happy New Year

to all our members and friends
and to the children they serve

CEREBRAL PALSY PROFILE IN MISSISSIPPI

N. B. BOND

THE data reported here, drawn from the files of the Crippled Children's Service in Mississippi, represent 300 unselected cases on the rolls of the cerebral palsy program of free state clinics in 1950. Since the total number of active cases was 737, this seemed an adequate sample from which valid percentages could be derived. Statistics are reported in the accompanying table. The following comments should be considered in evaluation:

Sex. The proportion of males to females in the general population is assumed to be close to 50:50. These figures show an excess of males in the incidence of cerebral palsy.

Race. Although the population of Mississippi is nearly evenly divided between whites and Negroes, the number of white children seen in cerebral palsy clinics amounts to almost twice the number of Negroes. Is this difference due to less efficient reporting of cases among Negroes? Or, is there actually a lower incidence among them? Veteran public health workers in Mississippi have said that Negroes report to free state clinics better than do whites. Further study is indicated.

Age. The figures show that the active cases come chiefly from the younger age groups. What is the explanation of the smaller numbers from the older groups? Is there a high death rate? Or, do parents stop bringing the older children to clinics? Whatever the answers to these questions, it is fortunate, since early treatment is so important, that younger children constitute the largest group reporting.

Intelligence Quotient. All cases of cerebral palsy are cases of brain damage. Hence, it is to be expected that the average IQ among them is lower than among persons of undamaged brain. If the lesion is located in the higher association centers, the victim is left with little or no intellectual capacity. These figures show that, while the incidence of amentia (congenital intellectual incapacity) is only 2 per cent in the total population, 40 per cent of these cases must be classed as aments.

Figures also show that the mental status of approximately 50 per cent of the cerebral palsy group is such that they present good prospects for treatment and training. Certainly 50 per cent can not be made self-sufficient economically and socially, but all of these can be helped in many important aspects, and probably 25 per cent of the total group can be made self-sustaining.

In 10 per cent of the cases, severe crippling prevented measurement of intelligence. A child may give the examiner the impression that he comprehends with fair intelligence, but that severe physical handicaps prevent him from responding appropriately to tests. If the psychologist can not arrive at a definite and valid opinion of the child's mental status, he must defer opinion.

• N. B. Bond is psychologist for the Crippled Children's Service in Mississippi

Occupational Status of Family. These figures do not show the actual incidence of cerebral palsy by occupation of parents because they include only cases brought into free state clinics. In the professional group there may be many cases that are treated privately and never reported in a state clinic.

School Attendance. Of the 240 children not attending any type of school, 150 were below school age. Of the 90 children of school age who were not attending, serious mental retardation prevented 62, and the remaining 28 were so badly crippled physically that school attendance was not feasible.

Handedness. Parents or other persons having charge of the child were asked about handedness, and the psychologist observed the child for handedness during the psychological examination. Tests were given when there was doubt. Crippling conditions, or the youth of the child made decision impossible in 58 cases.

Speech. This item was reported in very general terms. If a child has no speech, or his speech was so poor he could not converse, speech was reported as "poor." If he could speak well enough to be understood, but there was a speech impediment, speech was reported "fair." If he spoke well and without impediment, speech was reported "good."

Clinic Surgeon's Diagnosis. It is interesting to compare the figures for this group with those of Dr. Pohl's Minneapolis study of 144 cases,[1] which showed 66 per cent spastic, 19 per cent athetoid, 8 per cent ataxic, 4 per cent with rigidity, 2 per cent with tremor, and 1 per cent of mixed cases.

[1] Pohl, John F. M.D., *Cerebral Palsy*, 1950. Bruce, St. Paul. 18p.

ANALYSIS OF 300 CASES OF CEREBRAL PALSY IN MISSISSIPPI

Item	Number	Per cent
Sex:		
Male	174	58
Female	126	42
Race:		
White	198	66
Negro	102	34
1947 sample of 300		
White	206	69
Negro	94	31
Age:		
1-5 years	121	40
6-10 years	94	31
11-15 years	59	20
Over 15	26	9
IQ:		
Below 25	22	7
25-50	47	16
51-70	44	15
71-80	38	13
81-90	51	17
91-110	54	18
111-130	12	4
131-150	1	⅓
Undetermined	31	10
Residence:		
Rural	138	46
Urban	162	54
Family's Occupation:		
Farming	107	36
Skilled Workers	95	31
Common Laborers	35	12
Commercial Sales	23	7
Professional	14	5
Undetermined	26	9
School Attendance:		
Attend school	60	20
Do not attend	240	80
Handedness:		
Right	138	46
Left	76	25
Mixed dominance	28	10
Undetermined	58	19
Speech:		
Poor	183	61
Fair	83	28
Good	34	11
Diagnosis:		
Spastic	143	48
Athetoid	76	25
Rigidity	60	20
Ataxic	8	3
General Retardation	13	4

Teaching Homebound Children

J. A. RICHARDS

THE education of homebound children has long presented a difficult problem for the teaching profession. The main link between the school and the child has been the home teacher. While many of these teachers are doing an outstanding job, it is obvious that a few hours of home instruction a week is a far cry from daily, full time class participation. And to aggravate the problem, qualified home teachers have been hard to find.

School to Home Telephone Service

Now, however, there is a way available to supplement and make more effective the work of the home teacher, by, in effect, bringing the *school to the child.* It is the School-to-Home Telephone Service, which is provided by the Bell System and independent telephone companies nationally. Electronic intercommunication units, of the type used in offices, are specially engineered for use with telephone lines. There is a home station with a talk switch and volume control for the shut-in child. This unit is connected by private telephone lines to an amplifier and a stationary or portable classroom station with volume control, located in the school in which the homebound student is enrolled. Extra plug-in outlets may be provided for departmentalized classes.

With this facility the homebound (or hospitalized) child hears discussions in the classroom by the teacher and students. When called upon to recite or participate in group or class discussion, the shut-in can snap a switch and talk to the class. So even at his bedside located far from the school, the homebound child can have a two-way conversation with his teacher and classmates and can participate in the classroom program.

This technique was developed over a dozen years ago in Iowa where more than a thousand children have received

• J. A. RICHARDS is director of the special education division of Executone, Inc.

part or all of their education via telephone. Although progress was impeded by wartime equipment and telephone line shortages, the fact that this system is now being used in 30 states throughout the country proves its educational and psychological value.

Teaching by Telephone is, of course, no panacea. Like any machine, it is no better than the use to which it is put. There is no substitute for actual participation in a normal classroom situation, or for the home teacher who must remain responsible for the child's education. However, for homebound students who cannot be transported to a class or in situations where special classes for handicapped children are not available, the School-to-Home telephone method offers actual participation, at least in an audio sense, in a real classroom situation. It offers the shut-in child the all important advantages of daily educational contact: a sense of belonging and participation with other children of his own age and interests.

Survey Findings on Proper Use

To further a broader understanding of the proper use and application of this method, more than a hundred installations in different parts of the country have been surveyed in a research program undertaken by the manufacturers. Results of the survey presented here are based on interviews and correspondence with the school superintendents, principals, special educators, class teachers, home tutors, the homebound children, their parents, as well as their physicians, who have worked with this method.

The following observations, revealed by this survey, reflect the opinions of qualified persons based on their own practical experience and critical evaluation:

(1) *Minimum Age*: Although in some cases younger children have benefited from the use of this method, the indicated minimum is a functional mental ability level of nine years, and a fourth-grade achievement level In some states the recommended minimum is higher. Obviously, as children mature and are better able to sense visual situations, the educational benefits are increased.

To assure maximum effectiveness in the use of this method it is recommended that at the outset a conference

be arranged with the parents, the family physician, the principal, the class and home teachers, the school psychologist and the guidance or special education supervisor. This group can analyze all factors pertaining to the needs and capabilities of the child, the interest and ability of the teachers, and the family situation. Then if the group decides that the telephone method is applicable, the basis for teamwork in using it for the greatest benefit to the child has been established.

(2) *Minimum IQ*: The recommended minimum is an IQ of 85. While high average to superior children have progressed through the Telephone-Teaching method to superior scholastic achievement, it is worth noting that many children of low average intelligence have also benefited—frequently achieving better grades than when they attended school or were confined to home tutoring. This may have been the result of effective use of the method by the teachers involved, who successfully overcame the visual limitations. An added factor may be that shut-ins exposed to less diversion and distraction have more time to reflect and retain the things they hear and learn during daily class participation.

(3) *Personality Adjustment*: An important sense of belonging through daily contact with his classmates—the social value of continued identification with his group—is just as important to the homebound child as keeping up his school work. There is much evidence that this is achieved with the school-to-home telephone method. Documentation of case histories shows that it brings faster psychological adjustment to a handicap or to enforced confinement. It is also reported that many children who have become depressed and introverted through long periods of illness have undergone marked personality improvement after a few months of telephone contact with their class groups.[1]

(4) *Types of Disabilities*: This method is being used for a wide variety of homebound or hospitalized children with cardiac, orthopedic, muscular, and contagious conditions or fractures. Not every homebound child is capable of deriving the full benefit from telephone contact with the class. Each situation must be studied in its entirety and the decision reached after many factors are weighed. In the words of one educator, however, the technique can be used for any homebound child of average intelligence who can hear, see, articulate, hold a pencil, and manipulate a switch.

(5) *Medical Reactions*: Although some physicians felt that this method might be overtiring and overstimulating, particularly in cardiac cases, a separate survey conducted by the Iowa Department of Public Instruction, shows that after actual experience these fears proved unfounded. Doctors are almost unanimous in acclaiming its psychological and therapeutic advantages. Many state that it has hastened recovery by stimulating social and educational interest. Unfortunately physicians are not always able to inform the family of the length of time a child can be expected to be homebound. As a result, the school, uncertain as to when the child will return, will delay making arrangements for this facility and may dispose of a protracted case with repeated medical exemptions. However, the school can frequently avert this situation by conferring with the doctor at the outset of the child's confinement.

[1] Case histories available on request.

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(6) *The Visual Limitation:* Resourcefulness on the part of teachers who have worked with this method has resulted in the development of an effective technique to compensate for the shut-in student's inability to see what is going on in the classroom:

(a) If a child has not previously attended a given class, a specially arranged visit will help the shut-in visualize the classroom and get to know the children.

(b) If this is not feasible, photos of the classroom interior as well as the school building can be sent to the child and a delegation of a few students at a time can visit the home to get acquainted.

(c) The teacher must remember to describe visual situations which occur in a classroom. If she momentarily forgets, other students or the shut-in will remind her.

(d) Visual and written material, and a copy of chalkboard work planned in advance, is transmitted to the shut-in by the home teacher or a neighboring child. Where it is normal procedure, audio-visual equipment and material—films, slides, charts, graphs, globes, etc.—are brought to the child by the home teacher.

(e) To describe laboratory experiments or visual demonstrations an articulate member of the class designated as "announcer" describes the action to the shut-in, in a low but audible voice.

The effectiveness of these techniques is demonstrated by the fact that geometry, physics, and chemistry are being successfully taught via telephone.

(7) *Classroom Technique*: Although in advance of the installation some teachers feared that this method would place an extra burden upon them to the detriment of the class, in most cases actual experience proved the contrary to be true. Very little change of teaching technique has been necessary. The teacher must merely remember that the shut-in child is there but cannot see. She must bring him into the regular classroom work as is the case with any other child, see that visual situations are described as previously mentioned, and co-ordinate her work with the home teacher. Marked benefits to the rest of the class, including improved behavior and diction, a sense of responsibility, and the fact that the class students learn better by helping to teach the shut-in, seem to offset the minor revision of regular classroom procedures.

(8) *No Substitute For The Home Teacher*: Teaching by telephone is recommended as a supplement and not a substitute for the home teacher; since the shut-in requires a reasonable amount of personal contact and supervision, he needs to be assigned the proper lessons and materials, and to be checked periodically on progress. The home teacher should co-ordinate her program with that of the class. Where there is a serious shortage of home tutors, and the telephone is used, the number of hours per week spent with the home teacher can be reduced; or the necessary personal supervision can be provided by the classroom teacher. She may visit the child after school several times a week and receive extra compensation for the task.

(9) *Privacy for Teacher and Child*: Before installation, some teachers have expressed a fear of being inhibited by the possibility that outsiders listening in might misunderstand a normal disciplinary situation. Although in practice this has never been a problem, the possibility can be eliminated by

an understanding between the school and home assuring cooperation in placing the child in a separate room during class hours. The teacher thus shields the child from household distractions, and is assured of privacy for herself and her class. Where it is felt, however, that the mother can be of help, and is capable of understanding the school's point of view, her participation should be encouraged.

(10) *Telephone vs. the Radio and TV*: Notwithstanding the dynamic and proven values of educational radio and television, they cannot replace the telephone-teaching method any more than either of them can take the place of personal home instruction or actual participation in regular or special classes. Radio and television do not provide the all important give and take between the shut-in and the class. The two-way conversation made possible by telephone provides near to normal participation in a classroom situation with the benefits of complete curriculum, daily instruction on the same basis as other students, and the satisfaction of being a participating member of a class group. In the final analysis, the home tutor or classroom teacher must take the responsibility for the education of the shut-in child. She can utilize any or all of these supplementary techniques—TV, radio, or telephone attendance, in any combination —to fill in her own over-all program.

Cost of Program—— State and Private Aid

Since rates vary in different localities and states, information on installation, monthly rental and wire charges should be obtained from your local telephone company.

In some cases rental charges have run as low as $13 per month, while in others the charge has been approximately $25 depending on the rates in that area and the distance involved. For secondary school installations equipped with outlets in the auditorium and four or five departmentalized classes, the monthly cost would run higher. Where several children are connected to the same class or classes, the per pupil cost is less.

Although there is usually a six months contract minimum, some telephone companies will move the equipment from one location to another for a different child within that period, making an additional charge only for the reinstallation. Bell and most independent companies provide a complete service on a rental basis while other independent telephone companies merely lease the telephone lines to the school or family who purchases the equipment outright.

Approximately 23 states which have programs of special education for handicapped children have approved this method for partial or full state-aid reimbursement. In many parts of the country, service clubs, associations, foundations interested in handicapped children, and other organizations have helped to underwrite this service.

Need for Continued Research

It is hoped that this report will act as a springboard for continued research needed for proper evaluation of the educational effectiveness of this procedure and development of improved techniques for its use. We have made every effort to be objective. In pointing out the limitations of the technique, we have deliberately underplayed the emotional aspects, and have made no attempt to detail the many exciting case histories in our files.

(Continued on page 139)

Clinical Service Extensions

FOR RURAL AREA EXCEPTIONAL CHILDREN

RUTHERFORD B. PORTER

This is the third of a series of articles on clinical services edited by T. E. Newland, assistant professor of psychology, Northwestern University. Dr. Porter writes from a background of field work in rural Pennsylvania and a combination of teacher training and special education clinical service in teachers college. The views expressed here are, of course, those of Dr. Porter.

IT has been said that the problem child has stolen the show, that tests and courses of study are directed toward emotional maladjustment and delinquency, rather than adjustment and good citizenship. If this be true, does the responsibility for this condition lie with the clinician who constantly has been trying to render improved services, or with the public school in the nature of the services which it expects and seeks? As long as there are children with problems, there will be a real need for expert assistance to public school personnel and to parents in discovering such exceptional children, in ascertaining the nature of their problems, in developing appropriate adjusted or remedial programs, and, probably, even in helping to put such programs into operation. The quality of the assistance thus rendered can only be improved by the joint efforts of the competent clinician and of public school personnel who have been sensitized to the merit of psychological services that go beyond the IQ.

There seems to be no doubt about the seriousness of the need for doing more for exceptional children. The estimates of incidence of exceptionality of each type made in 1930 at the White House Conference remain approximately as they were reported. Several rather complete studies and many spot studies made since that time tend generally to substantiate this record. Understandably, the statistics for rural areas are the least accurate. Statements of incidence, either in numbers or percentages, are necessary to denote the seriousness of the situation. The problem is large enough to justify careful study. A 1952 US Office of Education release[1] estimates 5,000,000 school age exceptional children in the nation, and not more than 15 per cent of that number receiving special help.

Two things concern us about these figures. One is that, of the 4,250,000 exceptional children who are not receiving help, many are living in rural areas. Second, although the percentage of incidence indicates that there are many unaided exceptional children, in very few of the rural areas are these exceptional children known by name. It is much easier to estimate the number of hard of hearing children in a certain county than it is to determine exactly who they are, what are the amounts of their learning loss, and

[1] Federal Security Agency, Office of Educ., FSA-D42. Release, 16 Jan. 1952.

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then to decide what should be done for them.

What Clinical Services Should Do

Clinical services provided for the rural areas should be recognized as having two essential aspects: (1) the locating and diagnosing of exceptional children, and (2) the recommendation needed with respect to the placing of such children in special classes. Too often it is believed that special classes for mentally retarded children, for instance, can be organized, provided the school population is large enough, without a sufficiently psychologically sound procedure for determining the eligibility of the children for placement in such classes.

It would be well to remember that the first clinical program with children, nearly 50 years ago, was organized around this very problem when Binet was given the assignment of discovering which children really could not learn well. He, in turn, had first to devise a clinical instrument which resulted in the original Binet Scale. We all know that there has been much progress in devising clinical tools since Binet's original assignment. We also know that a successful program for special classes for mentally retarded has to go along with careful analysis of the learning level and learning rate of each child before placement is made.

Those involved in, or dealing with, special education must realize that the success of their programs depends on adequate clinical services. These services must be available before the program can start and must continue as long as the program continues. Knowing the exceptional children by name today does not assure knowing them tomorrow unless continuous study is made.

Clinical services for exceptional children started in urban areas, probably because of the concentration of population, where a greater absolute incidence of exceptionality came to the attention of the authorities and made some definite action imperative. The rural areas have not faced the same pressures. As a result of the nature of the distribution of the population in the rural areas, the attendant potential transportation problems, and the limited physical facilities available there, rural administrators, as well as the public, have not felt as keenly their equal responsibility for educating their exceptional children.

Need for State Leadership in Rural Programs

Just as it is true in urban areas, just so is it necessary in rural areas that arrangements be made for adequate psychological services before a sound special education program is started. However, each local school administrative unit need not have its own complete psychological clinic. State, county, and joint district organization of psychological services are ways that have been utilized in meeting this critical need in the rural areas. It is believed by this writer that the initiative for providing such psychological services for rural areas has to originate "at the top."

Illustrative of how such services were started at the state level is the county supervisor of special education program which was pioneered in 1939 by Pennsylvania.[2, 3] As one of the first

[2] Newland, T. E. "County Supervisors of Special Education in Pennsylvania." *J. Exceptional Children*, Oct. 1942. 9:1:23-25.

[3] Weiss, Emalyn R., and Myer, Lester N. "Psychological Services in the Rural Schools of Pennsylvania." *Exceptional Children*, Oct. 1952. 19:1:15-18.

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three supervisors appointed under this program, the writer can attest to the difficulty such a clinical program had in the beginning. Wanting to fit clinical provisions into a conservative, well-established school program, he asked the county superintendent what the best initial steps for the clinical program would be. The response was "We hired you to know that answer." One might conclude from such a response that a well-trained person could then organize his own conception of a good program and carry it out with comparative freedom. However, such is not usually the case. Especially in the beginning of the Pennsylvania program, many county supervisors of special education were concerned with as many as three counties, usually with each county operating under a different philosophy of education. A program which was well received in one county was sometimes impossible in another. This pattern of experience was shared by many of the early Pennsylvania county supervisors of special education.

Interestingly enough, it was possible to develop programs that were both sufficiently individualized to fit the needs of the several counties and at the same time to inaugurate activities in the interests of a variety of exceptional children. This program, even if "imposed" by the state department upon the rural areas, evoked a surprisingly prompt and unanimously enthusiastic support among the county superintendents, rural teachers, and parents throughout the state.

From this experience two points seem evident: One, that many of the counties cannot start their own programs because they so seldom know how, and second, that no one special formula can be established for clinical services in rural areas; rather, each program must be tailored to the local needs.

While Pennsylvania probably provides the most thorough pattern of such clinical service to rural areas, certain other states, like Illinois, provide a much more limited though somewhat similar service. In the case of Illinois, this service is legally provided by the state primarily for candidates for placement in their classes for the educable mentally handicapped, but the service is not confined to the rural areas. In other states, such psychological services are regarded as essential to the fuller understanding of all types of exceptional children, or to several of the types.

The number of county school programs providing their own psychological services without specific inducement from state departments of education is decidedly limited, and these counties, as a rule, tend to be the more densely populated—so much so, in fact, that they may be regarded here as being essentially urban in nature. Illustrations of these are situations in such states as California, Wisconsin, and New York.

The University Clinic's Contribution

It is unfortunate that we lack specific quantitative information as to the extent to which clinical services for exceptional children are provided our rural population by college and university psychological or psycho-educational clinics. While the total of such service in the interests solely of exceptional children, if ascertained, would in all likelihood be only a meager fraction of that which is actually needed, it is the writer's guess that a not insignificant contribution to the rural areas is thus made. In some states, such clinics are encouraged and nur-

tured by the state departments of education. Some even require state approval of such clinics even before their findings can be used for special class placement. In other states, clinics operate on a free-lance basis, according to how the particular institutions or staff members perceive their relationships to their service areas.

Each of the Indiana state colleges for instance, has an outpatient clinical service, mostly without charge, where schools, parents, or others may refer children for rather thorough study. Some of the clinics specialize in one or two types of exceptionality, but most of them do not concentrate their efforts. There is more emphasis, especially for rural children, on a diagnostic type of clinic service rather than a re-educational one. Most of the re-education carried out in such a clinic is utilized as a part of the clinic's training program in the college.

For example, the special education clinic of Indina State Teachers College is approximately 50 per cent a service clinic and 50 per cent a training clinic. The service clinic accepts children referred by city schools, surrounding county schools, parents, and various social work organizations such as the state department of welfare, juvenile probation departments, and the like. Because the problems of exceptional children overlap, all types of exceptional children are accepted for study.[4]

Approximately 300 children per year are studied on this basis. Not more than one out of 10 of the children studied is scheduled regularly on a re-education basis. Recommendations for re-education are given to the parent, teacher, or others concerned. Follow-up and subsequent referral to the clinic often occur but are not regular policy. Such a program seems to be effective with many children, especially where medical attention is indicated and obtained. It is most effective in educational retardation problems where recommendations can be carried out by the regular teacher. Even with children who are hard of hearing, deaf, or partially sighted the visit to the diagnostic clinic, with resulting recommendations, often leads to more adequate meeting of the children's needs.

The problems of the mentally retarded, the physically handicapped, and often the young deaf child are not properly solved solely in diagnostic clinic study. The recommendation in these cases is regular and continued instruction in a special room or school with other children having similar problems. When special class or other special education facilities are lacking, the effectiveness of the clinic's contributions is either impaired or negated.

The Local School Administrator and Clinical Services

Clinical services in Indiana and elsewhere are meeting certain of the demands of at least the pressing requests. However, the larger needs for clinical services for exceptional children so often are not being met. Neither the parents nor the school seem to be fully aware of the scope of the problem either as to the number of children needing such services or as to just what should constitute adequate clinical services; if they were aware of these facts, the requests could not be met through existing facilities. The problems of the exceptional child constitute an area that appears to be sorely

[4] Porter, Rutherford B. "Exceptional Children in Rural Schools." *J. Exceptional Children*, Jan. 1945. 11:4:110.

neglected in the training of school administrators.

However, the responsibility for inadequate special education programs cannot be placed solely on rural school principals, although their lack of understanding may be a factor in certain instances. Last year, a young man with teaching and administrative experience completed two years of graduate study, majoring in counseling, guidance, and school psychology. He accepted a position as school principal in a rural and supposedly progressive school district. He knew that responsibilities of general administration would take most of his time but there seemed to be an excellent opportunity to organize a program of clinical services for exceptional children. The school year is now nearly over and a recent conversation with him reveals that not even the first move toward such a program has been made.

It seems likely that no program can soon develop although it seems that practically none of the blame can be placed on the principal. He just hasn't time. Few people realize the breadth of activities and responsibilities of the rural area principal. Many of them are expected to teach a class or two, to organize the school transportation system, to make teacher assignments, and try to keep a program operating smoothly, to prepare orders making best use of limited funds for instruction, to attend all school activities including athletic events, and to do a seemingly endless number of other things related to the general conduct of the school.

State legislatures have done a better job of recognizing the needs of exceptional children by passing special education laws than school personnel generally have in making use of the provisions established. Indiana,[5] for example, has adequate legislation to permit and even to encourage, by financial reimbursement, programs for exceptional children. The Teacher Training and Licensing Commission of the state board of education has furthered the program by preparing and approving adequate certification qualifications for the specialists. The provisions pertain, of course to both urban and rural areas. However, a study of the requests for reimbursement in Indiana show that until recently it was largely the cities, not rural areas, which had established programs.

What Holds the Rural Areas Back?

Why do they not progress as cities do? The establishment of special classes is not all there is to special education. Other special education facilities are possible under the special education laws of most states. This failure to meet the needs of exceptional children cannot be attributed entirely to a general belief that there is no problem. In Indiana, as in many other states, a state law provides, for instance, for hearing survey tests of both rural and urban school children several times during each child's school years. Because of the lack of trained personnel and for other reasons the exact letter of these provisions may not be followed in all areas but most school administrators make arrangements for this survey. The hard of hearing children, then, are located by name and in this one area of exceptionality the extent of the problem is apparent. If

[5] Rules and Regulations Governing Applications for the Establishment and Continuance of Special Classes under Provisions of Chapter 211, p. 599 of the Acts of the General Assembly of 1927 and Vol. 2, Chapter 276, p. 1102 of the Acts of the General Assembly of 1947 (Revised and approved January 16, 1950).

knowing the extent of the problem would then assure establishment of a necessary special education program, most Indiana areas would have programs for hearing conservation which started with initial testing and proceeded to whatever provisions for remediation were needed including speech correction, acoustic training, lipreading, and perhaps some hearing aid fitting. But they do not.

Groundwork for Rural Clinical Services

Clinical programs for exceptional children in rural areas face many hurdles; but they are hurdles, not walls. In some cases state administrations are pioneering such programs while in others the colleges and universities are taking the lead in that direction. Pioneering can be done also by local administrators who have vision. No matter who initiates the program, certain groundwork must be laid first. Then development, although not necessarily the same with respect to all areas of exceptionality, should take into consideration the following facts, essential in any established program:

(1) Adequate laws are necessary.

(2) Inspired and capable leadership on the state level seems highly desirable in encouraging rural schools to initiate special education programs.

(3) Suitable certification standards are necessary so that qualified personnel can be found, but the standards cannot, at the beginning, be so strict that no one can qualify.

(4) Extra state support for special education is an excellent motivator for beginning programs.

(5) The school principal, even though he may himself be qualified to organize and perform clinical services, will not find time to do more than administer the program—and that somewhat from a distance.

(6) A qualified leader who can set up adequate clinical services should be employed first, so that initial surveys can be made and particulars for starting a program can be discovered. This includes discovering the children's needs, investigating the availability of special teachers, housing, considering the possibility of joint district responsibility for special classes and services, and the like.

(7) After the original survey is completed, a special education program, perhaps for one type of exceptionality at a time, can be put into operation.

(8) Continued clinical services must be available for further diagnosis, check on progress of individuals, and re-evaluation.

(9) Outpatient services offered by college clinics and other specialized non-local organizations should be used on a consulting basis for difficult cases, and for other technical assistance. Complete dependence on such facilities should be avoided.

(10) Rural school areas will further their own programs, and special education programs generally, if teachers and administrators encourage capable high school seniors to prepare themselves in their college program to work with exceptional children.

HERESY?

If all men are created equal
Does it follow as a sequel
No lad should be helped to be
A source of creativity?

To help the handicapped makes sense—
Why not help for excellence
Good results can come direct from
Working both ends of the spectrum

Why should this be heresy
In a great democracy?

JAMES M. SPINNING.

The Right School Program FOR EACH HEARING HANDICAPPED CHILD

FREEMAN E. McCONNELL

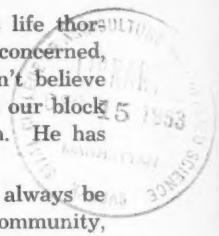
OUT in the Middle West there is a 10 year old boy named Eddie whose career shows what special education can do for hearing impaired children. At four, Eddie was a deaf boy with no intelligible speech. At that time he was placed in a special acoustic classroom for daily instruction with a trained teacher of the deaf. At six he began wearing his own hearing aid, and after one semester of a half-day in the special class and a half-day in the regular class he was transferred full time to the regular first grade. He is now in the fourth grade in a regular public school classroom.

A recent letter from Eddie's mother reports, "Eddie got along just fine at school last year. He stayed in the advanced class of his grade all year.

"At the end of the term I asked his teacher if there was anything I should coach him on this summer. She told me. . .he was fully qualified for fourth grade. . . .

"Eddie's speech is only a little short of normal now. Another year or two and people will have forgotten Eddie couldn't talk at all when he was five. And already his hearing aid is unnoticed.

"He still needs lots of help. But he needs less all the time. In the meantime, Eddie enjoys life thoroughly and as far as he is concerned, he isn't handicapped. I don't believe he ever will feel so. Life in our block sort of revolves around him. He has lots of friends."



The story of this boy will always be gratifying to his home community, which has demonstrated its belief in exceptional children by providing the special facilities which each child required to avail himself of an education. Eddie needed special school training at three or four to acquire the language tools necessary for reading, writing, and arithmetic at six. In the special class for preschool children, the community is taking its responsibility for furnishing the particular educational handling which can, in large measure, overcome the handicapping effects of hearing impairment.

Degree of Hearing Loss and Most Suitable Educational Placement

Today throughout the nation many more local school systems are beginning to plan special education programs for their hearing impaired children. Guidance in these plans should stress the fact that a program for children with hearing loss must always be one which gives full consideration to each indi-

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vidual child. Hearing handicap for any particular child is, by and large, directly proportional to two factors—the degree of loss and the age of onset. The best school program is one which provides the special help that will enable the child to compete with hearing children in his classroom or, if full-time special classroom instruction is necessary, will ultimately make regular classroom participation possible.

The hearing conservation program with its annual screening tests is a vital part of the special education program, for this represents the most efficient way to detect those who will need to be added to the special services yearly. A large number of children will be discovered with losses so mild that no handicap in communication has been apparent to them or to the teacher. For these, medical treatment will often prevent further loss. But educationally some kind of a guide is needed to determine how much handicap a particular audiometric curve signifies.

With the pure tone audiogram as the framework of reference, hearing loss may be quantified in decibels with the *zero db* horizontal line at the top representing the average threshold of normal hearing. The three frequencies from 500 cps through 2000 cps delimit the frequency area of the audiogram which research has demonstrated to be the most important for hearing speech sounds. It is both meaningful and practicable to use the average loss for these three pure tones to denote in one score a quantitative measure of a child's ability to hear speech as compared to normal hearing persons. A loss of from 1 to 20 db is generally not significant, and for all practical purposes may be considered normal hearing. When the better ear has a loss greater than 20 db, however, there is a need for special attention, and from 21 to 35 db is a range indicating a need for lipreading instruction.

Children having such losses are certain to miss much of the classroom speech. They should remain in the regular class, but they should be seen once or twice weekly by the itinerant lipreading teacher or speech correctionist. The goal of such training should be to give the child insight into his particular kind of hearing problem and an appreciation for the role of visual clues in supplementing his hearing to make communication easier. Speech correction may be necessary if the child's speech was not well established prior to the age of onset. The need for such remedial instruction is often greater when the audiogram curve slopes downward, indicating near normal acuity for vowel sounds, but quite marked inability to hear the consonants.

The next range to consider includes the levels of hearing loss from 36 to 65 db. The hearing aid will most certainly be needed in the classroom when the loss approaches 40 db. The range from 40 to 65 db represents an optimum one for hearing aid use. The special education measures necessary here are directly related to age of onset. Children having losses this great (particularly 45 db downward) during the normal period of speech development will not have oral speech and language, for they will not be able to hear the spoken voice well enough to learn to speak without special help.

Figure I depicts the audiogram of Robert, a boy who was failing in school because of his rather severe hearing loss. He was given special instruction at a hearing and speech clinic, fitted with a hearing aid, and his education in the regular class was continued with success. This child did not need segre-

gation in the special classroom. He needed only to hear again the sounds of speech he had lost. Because the onset occurred after the development of speech and language, although special help was needed, the techniques of regular classroom instruction were adequate after successful restoration of his auditory capacity through a wearable hearing aid.

In contrast, Eddie's audiogram in Figure II illustrates a loss not quite as severe as Robert's. But because in the beginning Eddie was a "non-language" deaf boy, the task of special education was to help him acquire oral speech and language through utilization of his residual hearing. Development of his latent auditory capacity enabled him to enter the regular classroom. Achievement of this goal required two years of preschool training and one year of primary school work in the special classroom. But Eddie had the ability and also, what is *most important*, enough residual hearing to make this goal possible when educational placement geared to his individual needs was provided. Eddie is now a hearing boy—not a deaf boy, thanks to special education.

The fourth range of the audiogram to consider is from 66 to 100 db. Losses below 75 db are considered quite severe. Prognosis for successful hearing aid use becomes less and less favorable as the severity of the loss increases. The range of frequencies heard often becomes more and more restricted so that complete speech patterns can never be heard by the child. Educational placement of children with such profound losses must take into consideration a number of factors. Unless such a child's speech and language are established prior to the loss, in most cases his educational needs can best be met by the residential school.

Only when the day school program in the public school is extensive enough to give graded work through the upper elementary levels to small groups in special classes can the public school program begin to meet the needs of

FIGURE I

Audiogram of a child who with hearing aid is able to attend regular classes; onset of hearing loss after development of speech and language

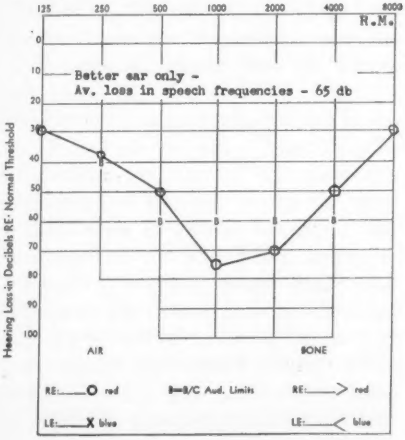
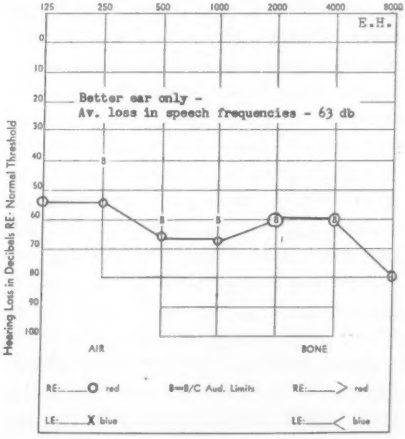


FIGURE II

Audiogram of child who with hearing aid is able to attend regular classes after three years in special preschool acoustic class; onset of hearing loss dates from birth



such children. In such a public school program, the school administration must certainly be firmly committed to special class instruction, and the system should be sufficiently large to provide an adequate number of deaf children to make possible the organization of such classes. While skilled private tutoring may, in some instances, be adequate, the personal-social development which comes from group instruction in the special class cannot be ignored in planning the best all-round educational program.

The best program for any hearing impaired child, then, depends on the child himself and his individual needs. It is not necessary to stand unequivocally on one side or the other in the day school - residential school controversy. Both programs are necessary, and both types must be extended and improved if every hearing impaired child is to receive his best kind of education.

Importance of Early Detection Followed by Special Preschool Training

To provide the best education for these children, the emphasis today is on early detection of hearing loss by means of accurate testing and diagnostic clinics. Through hearing conservation programs in the schools and health departments and through the growth and development of hearing and speech centers, communities are being educated to notice hearing problems. There are growing efforts to arouse parents to signs of deafness in infants, since detecting hearing loss during the first year of life is vital in paving the way to oral speech later. Many helpful suggestions on the home training and handling of deaf children from one to three are now available from specialized personnel in hearing clinics. The parents can do a great deal in this period to establish an oral attitude in the child by making him aware of communication and by encouraging the use of any vestige of hearing that remains.

Formal instruction at the nursery level can begin at about the age of two and one-half to three. Daily instruction from a trained teacher of the deaf for hearing impaired children from three to six is the ideal approach to the educational problem which hearing loss presents. During these years the normal hearing child is acquiring automatically and unconsciously the language background which enables him at about six to associate a mental concept with a printed symbol, and thus he learns to read. The child who does not hear the spoken voice is prevented from acquiring the language tools which make education in the ordinary sense attainable for him. Yet, the optimum period for developing speech and language is in this preschool period, whether for a hearing or a non-hearing child.

Research Findings on the Significance of Acoustic Training

The establishment of special education programs in the public schools has been given tremendous impetus during the past decade by advance in electronic engineering. Through the use of auditory training units which are commercially available, the world of sound can be brought to children in spite of severe hearing impairments. The improved fidelity of reproduction of sound, along with the reduction of size which makes possible a compact, light-weight unit, makes the wearable hearing aid practical for the very young child today. When only bulky two-piece instruments with heavy batteries and numerous cords were available 10

years ago, they could hardly be recommended for the young child, although he might otherwise have been psychologically ready for continuous auditory stimulation.

Experience is demonstrating that the sooner wearable hearing aids are used, the more rapidly speech will develop. This is not surprising when we consider that the normal hearing child learns to speak by hearing others over and over, day after day. He is bathed in an endless flow of speech. It is small wonder, then, that 15 to 30 minutes of acoustic stimulation daily at a group hearing aid is inadequate. The sooner that a deaf child can transfer from the group unit to a wearable one, the better are his chances of attaining the functional speech and language which will allow him to go through school with hearing children. Of course, the time to recommend the wearable aid depends on many factors—the psychological readiness of the child, the intelligence level, and the home attitudes. All circumstances need to be favorable, but early preschool training which stresses the utilization of residual hearing can make attendance in regular public school possible for many hearing impaired children when they are six or seven years of age.

The importance of acoustic training in the program for children with hearing loss has been recognized now for a number of years. Too often, however, only lip service is rendered, while traditional, less successful methods are used in daily training. It is not uncommon to see group auditory training units in use in all the primary classrooms, and no wearable hearing aids on the older children. The acoustic program must be thought of as a continuing one, and the introduction to sound through the group table aid is only the first step toward the objective of continuous wearable hearing aid use as soon as is practical for each child.

Emphasis on accurate diagnostic tests followed by wearable hearing aid use for some children as young as 13 months is achieving encouraging results as reported by the Johns Hopkins Hearing and Speech Center. Hardy and Pauls have reported that results from skin resistance audiometry with 456 preschool children ranging in age from 4 months to 5 years gave a mean hearing loss of 61.9 db (1). More than half of this number were thus found to have residual hearing of 65 db or better. The implications of this report reinforce the necessity of early diagnosis followed by special training and hearing aid use at the earliest possible time to enable the children who can profit from such methods to develop speech and language comprehension normally.

While there are still many interesting implications for research, there is now plenty of evidence to support the use of acoustic training even with the severely impaired hearing loss cases. Studies by Myklebust (2) and Hopkins and Hudgins (3) support the general conclusions that acoustic training can be used successfully with children whose losses are very severe, and for whom, in the past, restoration of any functional auditory capacity was thought impossible. These studies indicate that if educational programs for hearing impaired children make the fullest possible use of accurate diagnostic facilities, followed by training techniques using modern equipment, infinitely better work than is now being done can be expected. To the administrators who say this kind of education is too expensive, it can truly

(Continued on page 131)

Intelligence Tests

FOR VISUALLY HANDICAPPED CHILDREN

GERALDINE SCHOLL

TEACHERS in the field of work for the blind have searched for some years for an intelligence test that is adaptable for the visually handicapped. Group tests are not readily adaptable since there is greater variation in rate of reading in Braille than among sighted readers who use print. Also, many blind persons do not read Braille, either because they have not been trained to read it or because they refuse to read it for psychological or emotional reasons. Consequently individual tests of intelligence have been most widely used.

In 1942, Samuel P. Hayes of Perkins Institution for the Blind published his second revision of the Binet. This test, known as the Interim Hayes-Binet, has achieved great popularity and has proved satisfactory for use with blind and partially seeing students in schools and classes for the blind. Shortly after the publication of this test, Dr. Hayes recommended that as an alternative scale the Verbal Series of the Wechsler-Bellevue Test of Intelligence could be used. He suggested that all six of the verbal tests be administered and the results prorated. These two tests have since been used with the blind very successfully (1).

Recently, after the publication of the Wechsler Intelligence Scale for Children (3), Dr. Hayes recommended the use of this test for blind children under the age of 10 as a alternative scale, since the Wechsler-Bellevue could not be used with children who are under 10 years of age. An alternative scale for young children is frequently necessary and of great value in diagnosing the abilities and for proper placement in a school program (2).

During the past school year we have used this scale with some of the students enrolled at the Michigan School for the Blind. The purpose of this paper is to report some of the experiences encountered in the use of this test with blind and partially seeing children, to describe the adaptations that were found necessary to administer the test to this type of student, and to attempt an evaluation of the merits of this test for the visually handicapped.

The test was administered to so few children that any detailed statistical treatment of the results is not possible at this time. Furthermore, it is not possible to draw any conclusions about the use of the test with so few subjects. Consequently this paper will be a description of experiences and a subjective evaluation with the hope that others who use this test with the visually handicapped will share their experiences at some future date.

Description of the Sample

Twenty-three students enrolled as regular students at the Michigan School for the Blind were tested. They ranged

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in age from seven years, two months through 14 years. Grades two through eight were represented. Most of them (15), however, were in the fourth grade. Re-tests are done on the fourth grade level in our testing program which accounts for the majority being fourth graders. Seven of the students were new to our school last year. Fourteen of the students had sufficient vision so that the entire series was administered. A description of the experiences encountered in administering the entire series will be found in the following section.

These 23 students came from all parts of Michigan and six of them were residents of the city of Lansing and were day students in our school program. There were 16 boys and seven girls represented. There was a Negro boy (an albino), and an Indian girl included in the group.

On 16 of these students we had a previous test score from the Interim Hayes-Binet. However in most instances this test had been administered three or four years ago.

Administering the Test

All 12 tests were administered to the students who were enrolled in the sight-saving division of the school program and the results were prorated. Similarly, all six tests of the verbal series were administered to the totally blind. We felt that since this was a new venture in administering the test to visually handicapped students it would be best to use all the available tests so that at some future time a more detailed analysis, and possibly a selection of tests that are more suitable for the blind, could be made.

For our school records, however, if there was a great difference in the verbal and performance IQs of the partially seeing students, we recorded only the verbal IQ. This seemed wise in view of the fact that it is difficult to determine how much poor vision penalized the student in the performance series of the test. In several cases the performance IQ was higher than the verbal. In these instances, the results of the full scale were recorded for our school records.

Standard norms were used for the entire group in computing the IQ.

Verbal Series

In the test of General Information, we omitted items one to three as directed with subjects eight years of age and over. We continued beyond the five consecutive failures in accord with Dr. Hayes' suggestion for administering the Wechsler-Bellevue to adults (1). Eight of the 23 students had a successful response after five failures. Four of these were successful on the item, "How many pounds are there in a ton?" Two of the remaining four were successful after five failures above on the item, "What is a barometer?" One of the remaining students had six failures and then gave the correct response to the question, "Why does oil float on water?" The other student had five failures and then gave the correct responses to: "What is celebrated on the Fourth of July?" and "What does C.O.D. mean?" Then he had six failures and gave the correct response to, "When is Labor Day?" This particular student has definite gaps in his knowledge. He is a non-reader in spite of his normal intelligence and has many emotional problems in his relationship with his parents. At the present time we are working with the parents to get some psychiatric help for the boy. His record suggests that in administering this subtest to the visually handi-

capped it might be well to continue through eight consecutive failures.

In General Comprehension all 14 items were administered to all except the little seven year old. The vocabulary of the items beyond number 10 was somewhat above her range of experience and the subtest was discontinued at this point after three failures. Of the remaining group of 22, six of the students had successes beyond the three failures. Three of these gave a correct response on the last item, "Why should a promise be kept?" following six, six, and three failures, respectively. One girl was successful on the item, "Why is cotton fiber used in making cloth?" following four failures. One boy was successful on, "Why do we elect senators and congressmen?" after three failures. The last student, a boy, was successful only on two items, "What is the thing to do when you cut your finger?" and "Why is it better to build a house of brick than of wood?" He gave one point responses for both these items. He is a youngster who has had very limited experiences, whose helpless and dependent attitude has hindered his development both at home and at school.

Two of the questions, "What would you do if you were sent to buy a loaf of bread and the grocer said he did not have any more?" and "What should you do if you see a train approaching a broken track?" are probably somewhat difficult for the blind child since his experiences along these lines are very limited. Seldom has this type of child the opportunity to go to the store alone. Similarly, his experiences with trains would probably be limited to riding on them.

In Arithmetic the first three items were omitted as directed in the manual. This was done also for the little seven year old because she is very bright. There were no particular difficulties encountered in this test.

In Similarities the four analogies were administered to all the students. We continued administering the pairs until at least five or six consecutive failures were encountered. This procedure seems to be unnecessary for this subtest, however, since only one student passed a pair after three consecutive failures.

In Vocabulary we administered the first 10 words to all students. This seemed to be indicated since so many blind students have a poor vocabulary and verbalize and use many words that they do not actually understand. This, however, would be unnecessary in most cases with a normal child of eight years and over. Unsuccessful responses were given only by those children who were of subnormal intelligence. The test was continued beyond the limit of five failures as recommended in the manual (3) to eight as suggested by Hayes in administering the Wechsler-Bellevue (1). This however did not seem to be necessary either since none of this group had a success following five or more consecutive failures. Consequently the Vocabulary test could probably be administered as directed in the manual. There were no particular problems with this test.

Digit Span was administered as directed in the manual with no difficulty to any of the subjects.

Performance Series

In Picture Completion we did make one variation in the directions. First of all we moved all the testing equipment close to the window or to the desk light so that the child was in the best possible environment. Then each child was asked if he could see well

V 2 0 / 3 D E 5 3 UMI

where he was and to tell the tester if at any time he would like to move his chair. These instructions are familiar to the child since in the school room he is permitted to move anywhere in the room where he can see best. To the instructions for this subtest the following was added, "You may take the booklet in your hands and hold it as close to your eyes as you wish." This seemed to work out well for all the children who were given this series. It permitted each child to hold the picture as close to his eyes as he wished and in the position where he could best see it. The children were usually so interested in the booklet that all the pictures were used. This seemed wise because they knew there were more in the booklet and they would feel they had failed if they were stopped in the middle of the project. Fifteen seconds was ample time for this too. Four of the 14 students who had this series were successful after four or more failures. One boy was successful on the umbrella following four failures; one boy was successful on the rooster following five failures; one boy was successful on the hat after four failures; and one girl was successful on the card after four failures. It would seem that the examiner would be safe in stopping after five failures if he could without endangering rapport. The pictures seem to be clear and well defined and students did not seem to have any particular difficulty with them.

In Picture Arrangement items A-D were omitted with the older students and the test was discontinued following two consecutive failures as directed in the manual (3). Those students with very poor vision encountered some difficulty with this test since many of the pictures are exactly alike except for one or two small details that they would overlook. For one student, timing was not begun until he had looked at the entire series. However he was most unsuccessful throughout the entire performance series because of his poor vision. Further study should be done on this subtest to see if beginning timing after the child has had an opportunity to examine all the pictures would be more fair to the partially seeing child.

Block Design presented no special problems. The instructions in the manual were followed with no difficulty. One child, who is also color blind, had some difficulty in manipulating the blocks but his score on this subtest was above his mean score for the performance series and so, seemingly, his color blindness did not handicap him there.

Object Assembly also presented no problems in presentation. However, the children frequently failed on the face having the eye inverted and on the auto having the lower part of the car door inverted. These two pieces have very tiny indications on them when they are in the correct position. The small marks seemed to escape many of the children. Incidentally this part seemed to be most enjoyable to the children and they were always disappointed to have it end.

Coding B was used for all 14 of the students since all of them were over eight years of age. The test does use vision to a great degree and those children with nystagmus were very poor on this part since their lack of muscular control prevented working with any speed. We used the large black primary pencil that is familiar to them for doing this test. So many of the children had to get their heads down so close to the paper that looking from the Key to where they were working took a great deal of time. Nine of the

students received scores lower than their mean for this series on this particular subtest. It would seem that since the time allowed for sight-saving students to complete the Stanford Achievement Test is one and a half times that for normal sighted students, some allowance should be made on a timed test that involves speed of eye movement to the extent that Coding does.

The Mazes section also involves the use of the eyes to a great degree and many of the students were unsuccessful on this test too. Again, the, large, primary pencil was used. Here too we were somewhat liberal in scoring the lifting of the pencil as an error. Some of the children had to get their heads down so close to their hands that lifting hand and pencil from the paper to study the next move seemed necessary.

Summary of Results

With such a small number of cases it is not possible to give a detailed analysis of the results we have obtained so far. However some comments on the results might be enlightening.

Nine totally blind children were given this test. The range was from 82 to 115 in IQ on the Verbal Series pro-rated. The median was 94. It is interesting that the median corresponds with the median IQ for the school for the totally blind students. The median last year was 95.

Fourteen partially seeing students were given the test. A break-down of the results may be found in the following table.

IQs OBTAINED BY PARTIALLY SEEING ON WISC

	Verbal Series	Performance Series	Full Scale
Range	65 to 120	64 to 124	62 to 123
Median	88	86	86

It is interesting to note that the median again corresponds to that found among the entire school population for the partially seeing. Last year this was 90. On the whole our partially seeing students test lower than the totally blind.

Sixteen of the students tested had been tested on the Hayes-Binet before. However, because of this small number we have not worked out any correlation.

Of the 14 students who took the full scale test five received higher scores on the performance series than on the verbal. It might be interesting to examine these five cases in more detail.

The greatest difference, 33 points, was made by a little Indian girl. During the verbal series she was very unresponsive and when she did answer it would be in as few words as possible. Further questioning would draw out no additional information. She refused to answer unless she was absolutely sure of something. During the performance series she said almost nothing but indicated by smiling that she enjoyed this part especially. Her IQ of 114 on the Performance Scale is much more in line with her school achievement than the IQ of 81 from the verbal series. She took much time to adjust to our school program but since she has become acquainted with the students she is more responsive. Her teacher feels, however, that she responds better to the other students than she does to him. Using the performance series for this youngster gave a much better indication of her true abilities.

The second largest difference, 14 points, was found in a boy. He has always had difficulty in school subjects and is probably one of those students who will adjust better to a fac-

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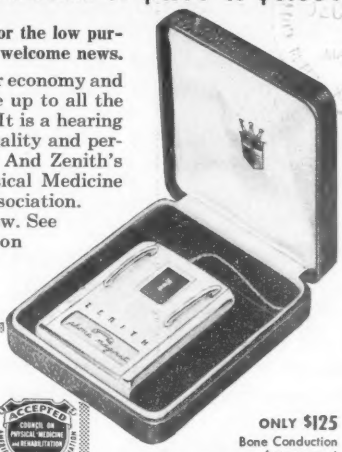

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tory position than to a job where language is essential. His home background is not especially conducive to learning to express himself. He received an IQ of 80 on the verbal series and 94 on the performance. His school performance is average for the group he is in. However, this is one of the classes for the partially seeing where the median IQ is slightly below average. He has adjusted well to the school environment and next year when he enters junior high school, he will take vocational subjects where he meets with more success than in strictly academic subjects.

Another boy had a difference of 13 points between his verbal and performance scores. This youngster was very anxious in taking the test. He would not respond unless he was sure of the answer and then when he did respond he would look up anxiously at the tester almost expecting to be scolded. This boy has not lived with his parents for several years since the court removed all the children from their custody because of cruelty. He has taken some time to adjust to school and dormitory life. Though he has a very low opinion of himself and almost seems to enjoy failure, he does excellent work in school and the teacher felt that the performance IQ of 114 was much more in line with his school progress and achievement than the verbal of 101. It was surprising to find the difference in this particular boy since he does not have difficulty expressing himself in school. He seemed to enjoy the performance part of the test much more than the other and perhaps was better motivated to do his best. He may not have felt that this was as much of a test as the verbal series and hence he could relax and do better work on it.

The fourth student, a boy, received a score of 118 on the verbal series and 124 on the performance—not a very great difference. This particular boy does not make progress in school in line with his abilities. He is a new child and had to adjust to the loss of his mother during the past school year. He was probably more highly motivated on the performance scale than the verbal since he seemed to enjoy the performance tasks more and does not have particularly poor vision.

The fifth student, a boy, showed a difference of two points. He is of subnormal intelligence and was accepted on trial this year pending commitment to a state institution.

Most of the differences where the verbal scores were higher could probably be explained by the child's lack of vision. Most of the other cases were borderline vision where vision seemed to penalize them on one or more of the performance tests.

Recommendation

It will be interesting to compare results of other schools in the use of this test for visually handicapped children. More research will have to be done and correlations made with previous tests and with the analysis of school achievement.

No special adaptations for the blind are necessary in administering the test for the verbal series. The entire series can be given with little or no difficulty to the totally blind child. The test materials are more interesting for the 10 to 15 year old and those in that age group seemed to like it better than the Wechsler-Bellevue which uses more adult materials. The tester may want to continue the various tests as indicated beyond the usual level of failure for his own interest in seeing what

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the child can do. Sometimes the learning and knowledge of the blind child may be more scattered than that of the normal child because he has a different range of experiences. This would necessitate taking him beyond the usual limits in order to discover his own individual limits.

The performance tests should be administered if the student seems to have sufficient vision for these tasks. It is interesting to try them out and much can be observed about the student during the administration of these subtests. The only variation would seem to be permitting the child to hold the booklet in his hands for picture completion and using a large pencil for Mazes and for Coding.

Many partially seeing children when enrolled in school are seriously lacking in experiences and the environment that makes them verbal minded. Since there are no performance tests that can be used with the totally blind child which will not penalize him for his lack of language ability, it is well for us to use performance tests that are available for sighted children in dealing with the partially blind. With this group, at least, some account can be taken of their lack of verbal ability.

It would seem that the Wechsler Intelligence Scale for children is quite adaptable to the blind and partially seeing and will be of value to workers in the field as an alternative test with the Hayes-Binet.

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A beggar, arrested at a downtown Detroit corner recently, had $337 in cash in his pockets and a bankbook showing a balance of $4,700.

"Where did you get the money?" the judge asked.

"I'm deaf, I can't hear you," the beggar responded.

"Where did you get this money," the judge shouted.

"I can't hear you," the beggar repeated.

"I'll fine you $150," Judge Skillman muttered.

"I won't pay it!" the beggar shouted.

So—he got 90-days.

PHYSICAL FACTORS IN MENTAL RETARDATION

CARLETON J. MARINUS

WE ARE too prone to classify each subnormal child as feeble-minded, a term correctly applied only to the directly inheritable mental handicap. The evidence shows that physical, chemical, neurological, vascular, nutritional, and endocrine disorders which interfere with mental development can produce mental retardation just as severe in degree as the retardation seen in true feeble-mindedness. In fact, such cases of delayed mental development far outnumber the cases due to faulty inheritance.

No treatment can be successful without a previous diagnosis. That dictum also applies to the school curriculum and to the teaching methods to be used. One can not obtain the maximum progressive education without diagnosis as to the etiology and type of handicap involved.

Competent Treatment

Therapeutic methods of treatment of the individual to improve his efficiency and rate of mental development are obviously dependent upon the diagnosis. Such methods are available in the presence of certain of the disorders enumerated. Other methods of therapy will be determined by adequate recognition of the abnormal factors present.

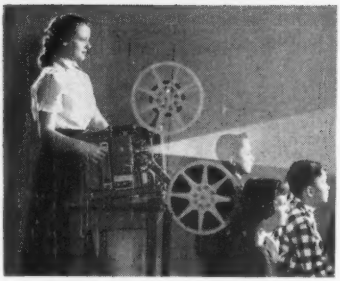
An equally important field in therapy is the evaluation of improved teaching methods demanded by the type of handicap involved. In remedial reading, for example, successful use of the newer techniques recently developed has emphasized the necessity of the proper diagnosis of the *individual.*

Continued Research

Because of the failure of the diagnostic program to cure an individual completely or to decrease the total numbers of mentally handicapped children, we must include in our over-all program a vital provision—namely, fundamental research as to cause and prevention of mental handicaps. Who, then, should organize, finance, and suggest avenues for development of such a program?

Parents, together, at a national level, can channel their individual desire to help, to "do something" into a united energy and force. We are now seeing the formation throughout the country of local, loosely organized associations of parents of mentally handicapped children. These small groups are bound together by a common emotional factor—the need for something to be done about their handicapped children. There is a common bond of sympathy, a relief of stress through common activity, and mutual help in the discussion of their common problem. Up to the present time there has been very little organization of effort. These associations are groping for leadership, for a definite practical program. For what the best program may be to help their handicapped children, they must look to those who have been working with many such children, and who know what needs to be done.

• CARLETON J. MARINUS is director of the endocrine clinic of Detroit's board of education.



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Special school administrators and teachers have the closest contact with the problems involved. They have the best training available. Up to the present time they have, to the best of their ability, organized programs for the study of the mentally retarded child as well as programs for specialized curricular and teaching methods. They have had years of experience and first-hand knowledge in the field. They are in the best position to know and understand the shortcomings of the present special school set-up. They can offer avenues for research and exploration through their knowledge of what is not, but should be, known about the child to foster his fullest development. Medical men who have worked with special education programs can suggest avenues for exploration of prevention.

Research at the national level as to causes of mental handicap would involve continuing measurement of the degree of handicap. More important, it would involve classification in terms of cause of handicap, disturbances in physiology, and so on. Most important of all, it would include research as to methods of prevention.

Records and Publications

As basic to research as the gathering of information in the three programs listed above is recording of all information. All new information, both positive and negative, both successes and failures, at the local level and at the national level should be recorded and published. A complete record of all facts should be available for future workers so that they may be able to find the information, avoid unnecessary repetition of effort, correlate the isolated findings, and finally interpret the findings into a logical and useful whole.

Here are some suggestions as to directions in which fundamental research might be oriented and examples of recently acquired information having a direct bearing upon the problem of mental retardation.

(1) Study of the parents' history before the child's conception. For example, Rh incompatibility potentially interferes with normality in the mental as well as physical field. Other factors which have not been studied but which are conceivably capable of producing mental retardation are: nutritional status, anemia, chronic infection, and endocrine status.

(2) Study of the first trimester of pregnancy. We have recently learned that certain virus infections occurring during the first trimester of pregnancy permanently damage nerve tissues. German measles in the mother during the first third of the pregnancy frequently causes deafness or blindness in the child. We should study the effect of abnormal nutrition, avitaminosis, infection, emotional upsets, and endocrine status in the first trimester.

(3) Study of the second trimester of pregnancy is an entirely different problem. It has recently been learned that certain bacterial infections during this period predispose to the development of congenital malformations, including those of the central nervous system. We again need to know more about nutritional status, excessive weight gain, inadequate protein intake and endocrine disorders and their effect upon the mental capabilities of the child to be born.

(4) The third trimester of pregnancy again introduces new problems which have not as yet been adequately studied. We do know that the toxemias of the last three months of pregnancy

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It Was In The Beginning — *OCTOBER 1948*
This Reprint Appeared in The Chicago Tribune . . . and the story went around the World!

20 CHILDREN HEAR 1ST TIME

Deaf Get Thrill of Lives with New Aid

BY JOHN THOMSON

A new life opened yesterday for children at the Ephpheta School for the Deaf, 3150 N. Pulaski rd., where for the first time many heard a human voice, and music and laughter entering their usually silent lives produced smiles, giggles, and wonderment.

For about 20 youngsters used by school officials in a demonstration of a new auditory training unit which develops high, clear volume without distortion, and for others who will use the unit, it was an eventful day. It meant the world of sound may replace the world of silent lip reading and sign language to which they are accustomed.

Listen Thru Head Phones

The auditory training unit, developed by Jay L. Warren, Inc., of Chicago, will enable many children not only to know sound and to help develop their speech, but will enable them to take part in a home life as normal as possible considering their hearing deficiencies, school officials said.

Each child listened thru a set of headphones, which transmits the sound from a central unit which is a combination radio, phonograf, and speech unit. The headset is operated by dual controls, enabling the child to adjust the volume to each ear so that when both receivers are tuned the sound will come thru both ears as thru one.

Hear Phonograf Record

Six children who had suffered a 50 to 75 per cent loss in hearing donned the headphones while Miss Dorothy Coughlan, a speech teacher, played a laughing record on the phonograf. They broke into smiles and giggles as they sat listening intently.

Another group which had a 90 to 95 per cent hearing deficiency showed lesser results. Some were able to hear, others heard indistinctly. Miss Coughlan said hearing conditions vary with each child, tho they be in the same deficiency range. Some may not hear at all even with the new unit, but teachers hope that with training they will eventually be able to distinguish sounds.

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have a harmful effect upon the mental development of the child. During this time certain mechanical difficulties may occur such as pelvic disproportion, abnormal position of the fetus, and so on. All of these factors have a potential effect upon the mental development of the prospective child.

(5) The period of delivery and the immediate postnatal period have recently had more study, and it is increasingly admitted that this is the time of extreme danger to the mental development of the child. More information must be obtained.

(6) Infancy. I do not need to go into detail nor stress the importance of disturbances in physiology, endocrine disorders, and emotional disorders. nor to point out the inadequacy of our present information.

Experience of the Detroit Clinic

For the last 20 years I have been associated with the endocrine clinic in Detroit. I see several hundred new patients each year for diagnosis, advice as to placement, and treatment of the individual. Some of the results achieved there and the methods used may be of interest in showing what other clinics might accomplish:

The endocrine clinic opened in 1928 in Detroit as a problem in research to study the possibility that some of the cases of retarded mental development might be due to endocrine deficiency. The original conception was that, if there were an endocrine disorder sufficiently marked to interfere with a child's mental development, there must be readily apparent physical signs of the disorder.

The first two years' work revealed that there was no correlation between disturbance of the pituitary function and mental development per se. It showed, however, a very definite group of children suffering from deficiency of the thyroid gland with low intelligence quotient and specific mental retardation. These amounted to approximately 17 per cent of the retarded children examined. Those children showing evidence of thyroid deficiency were placed on adequate thyroid treatment and followed by means of (a) estimation of the physical change resulting, (b) school reports covering the observation of the teacher (the teacher did not know which of the children were under treatment and which had been diagnosed and were being carried as controls), and (c) repeated intelligence tests. At the conclusion of the two-year study period, analysis of the results showed that beyond question the value of thyroid treatment in these cases was a maintenance of a higher IQ where thyroid therapy was instituted early enough.

At that time the work was taken out of the research department and made a permanent part of the department of special education.

At the present time the work includes: (a) examination and diagnosis of children under 10 years of age who show mental retardation and evidence of thyroid deficiency (These cases routinely have an intelligence test before being studied in this clinic), and (b) study of thyroid function in cases of speech disturbance and establishing the dosage of those cases in which it is indicated.

In the first group we have found that the cases of true mental retardation can be divided into five groups: (a) true inherited feeble-mindedness; (b) thyroid deficiency, either congenital or acquired; (c) brain injury, either at time of birth or traumatic or infectious, causing brain damage early

in life; (d) mixed thyroid deficiency and brain injury; and (e) a miscellaneous group including various pathological brain conditions such as Mongolism, Mongolism plus thyroid deficiency, microcrania, and hydrocephalus. Only cases showing thyroid deficiency are treated in the clinic.

Among the speech cases we have found a surprisingly large number of children showing retention of the infantile type of speech who are suffering from thyroid deficiency unaccompanied by physical signs. These cases respond well to thyroid treatment.

The mixed thyroid deficiency and brain injury group is of great interest. The child born with thyroid deficiency is incompletely developed. His vascular system is inadequate. He is more susceptible to injury during even a normal delivery than is the child whose thyroid function is normal. These cases usually appear as the result of a thyroid deficiency in the mother during the pregnancy. Thyroid treatment of the child will correct the part of the disorder due to the thyroid deficiency, but does not alter that part of the disorder which is the result of brain damage. These cases are much more difficult to treat and the result is much less satisfactory than in the group of uncomplicated thyroid deficiency.

As for Mongolism, a disturbance in development involving both the physical and mental fields, it is not amenable to any treatment known today. A large proportion of the cases of Mongolism are accompanied by secondary thyroid deficiency. Thyroid treatment is capable of correcting that part of the disturbance due to thyroid deficiency but has no effect upon the underlying Mongolism. This group is frequently confused with cretinism which is an especially severe deficiency of the thyroid.

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The number of children in Detroit suffering from the handicaps mentioned above is so great that it is not possible to diagnose more than a fraction of the cases that should be seen without either increasing the time, personnel, and facilities of the clinic, or eliminating the treatment of the case after diagnosis. For this reason the present policy of the clinic is to transfer the case to the family physician for further administration of the thyroid after diagnosis and after a program of treatment to establish the dosage for the individual case has been determined.

As the result of experience with Detroit's clinic, we have discovered that:

(1) The damage already present cannot be totally eliminated. There is no such thing as a complete cure. No mentally handicapped child ever becomes completely normal. Adequate treatment results in increased efficiency and an accelerated rate of mental development in direct proportion to the effectiveness of the treatment in the handicap involved. It is probable that continued study will give us improved methods of therapy and will widen the field for effective treatment. I do not expect to see a time when complete cure will be available.

(2) The total number of new cases remains unchanged. No matter how successful the treatment of the handicapped individual may become, that still does nothing to prevent these handicaps in the children of the future.

A Diagnostic Clinic Program

How should we proceed under the circumstances to the best benefit of mentally handicapped children? In every community large enough to have a special education program, a diagnostic clinic should be organized. We should have the conception that every mentally handicapped child deserves a diagnosis.

How shall it be organized? Each clinic should develop its own program. It would be narrowing indeed to say that the Detroit program or any other is the best. Let each clinic visualize the problem and work out the procedure that best meets the need. Its method may be entirely different from others. Because of this difference in method, new facts which we have missed must inevitably be found. In selecting a director, a young rather than an older doctor should be chosen. He has the energy; he has the time; he has the positive approach of hope; he has not learned what cannot be done; and he has not dug himself into a rut.

How shall we proceed in therapeutics? We should use all the information at present available. We should use new-found information. We should use adequate controls to determine the value or the lack of value of the medication used. We should individualize the treatment to the particular child, always bearing in mind that we are dealing with human beings who are loved by their parents and who must not be subjected to dangerous experimentation.

Such clinics would satisfy the need of parents by *doing something* for Johnny. Such clinics can be organized locally, can be financed without undue strain, and can result in measurable help for the handicapped individual.

How shall we proceed in treatment at the pedagogical level? There should be close association between the diagnostic clinic and the special education program. The information obtained in the diagnostic clinic should be available to, and should be used in solving, the teaching problems developing in the individual child. There should be frequent correlations of observations made in the two departments.

Summary

The mentally handicapped child needs an adequate diagnosis and treatment when his mental disorder is due to a physical factor that can be diagnosed and treated. He needs a special curriculum and teaching program in terms of his kind of handicap. These needs can be met to the best of our present abilities by local diagnostic clinics run by young doctors in conjunction with the special education department of local communities. Such a program will result in improved efficiency and accelerated mental development in cases amenable to such treatment. This program will, however, not cure a single individual, nor will it decrease the numbers of handicapped children.

We, therefore, need fundamental research at the national level to reveal all of the possible causative factors of mental defects, and methods of minimizing their effects and of preventing the damage. We need adequate reporting of all new facts, both positive and negative.

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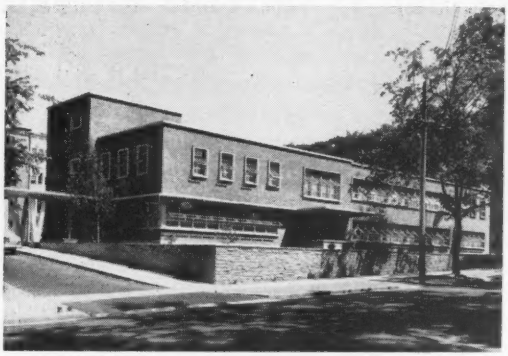
Summer Session Program for Educators of EXCEPTIONAL CHILDREN



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THE RIGHT SCHOOL PROGRAM

(*Continued from page 115*)

be said that the educational program which permits each child to develop to the utmost in accordance with the uniqueness of his own innate capacities is the most economical to the taxpayer in the end.

Summary

Special educators have a task ahead in convincing the public schools and the community of their educational responsibility for the preschool hearing impaired child. In the important years from three to six, the preschool acoustic class will, in a large measure, determine which children may be expected to make the transition from the status of deaf children to hard of hearing children for whom long-term special education will be unnecessary.

In every state, all the services for the hearing impaired child should marshal forces to see that the greatest possible number of children with hearing handicap make this transition.

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State Programs FOR THE CARE OF CRIPPLED CHILDREN

ARTHUR J. LESSER

FOR many years there has been much interest in the health and medical care of crippled children in the United States on the part of various private and governmental organizations. Since 1935, with the passage of the Social Security Act, there has been a considerable extension and improvement of services by state crippled children's agencies. This has been accompanied by an increase in the activities of the voluntary organizations and of parents' groups. There is mutual recognition of the roles of the public and voluntary organizations which complement one another in the development of services for crippled children.

The grants to the states of funds appropriated by Congress under Title V, Part 2, of the Social Security Act have enabled the states to

> extend and improve (especially in rural areas. . .)services for locating crippled children, and for providing medical, surgical, corrective, and other services and care, and facilities for diagnosis, hospitalization and aftercare, for children who are crippled or who are suffering from conditions which lead to crippling. . . .

The Act further specifies that state plans must provide for cooperation with medical, health, nursing, and welfare organizations and with the state vocational rehabilitation agency.

The Children's Bureau of the Department of Health, Education, and Welfare is responsible for administering Title V. Part 2. The federal funds appropriated to the 53 states and territories in 1953 amounted to $12,245,000. These funds are apportioned to the state crippled children's agencies in such a way that the states with the lower per capita income receive a proportionately larger share of federal funds. The total effect is that one-half of the $12,245,000 is matched by state funds. An important principle here demonstrated is that one function of the grant-in-aid fund is to help equalize opportunities for program development among the states, since the poorer states receive proportionately more federal money. Each state submits an annual plan and budget describing the program and the proposed use of funds.

The definition of crippling is decided on by each state, either legally or administratively. Within that definition, the state crippled children's agency indicates the types of crippled children it accepts for care. Initially these crippling conditions were virtually entirely orthopedic. Since 1939, however, there has been a steady increase in the numbers of children with other handicaps included in the state services. At present all states include children under 21 years who have a handicap of an orthopedic nature or who require plastic surgery. About half the states have developed services for children with rheumatic fever. Most of them provide services for children with cere-

• ARTHUR J. LESSER, M.D., is director of the Division of Health Services, Children's Bureau.

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bral palsy and a few include children who are hard of hearing and children who have epilepsy. Over half the states include children who have eye conditions which are amenable to surgery. The orthopedic services are statewide (except for some of the major cities). The other programs usually have limited geographic coverage due to insufficiency of funds and personnel.

In providing these services the state agencies hold crippled children's clinics at varying intervals in different parts of the state. The physicians are specialists who usually provide services in hospitals and convalescent homes, and are paid by the state agency on a part-time salary or fee basis. Hospital care is purchased on the basis of average daily cost per patient. In many programs a pediatrician participates with the orthopedist. Other personnel include the public health nurse, medical social worker, physical therapist, nutritionist, and speech therapist as needed, and various consultants.

The problem of the crippled child is complex. It is necessary not only to give medical or surgical care, but also to help the child adjust to the long difficult period of growing up with a handicap. The aim of treatment is to give maximum surgical correction, or medical improvement, as well as to help the child develop to his fullest capacity and make a satisfactory social and emotional adjustment.

In 1951, 228,873 children received physician's services under the state crippled children's programs. These are grouped diagnostically as follows:

Congenital malformations	48,022	21.0%
Bones and organs of movement	45,739	20.0%
Poliomyelitis	30,297	13.2%
Cerebral palsy	20,150	8.8%
Ear conditions	13,084	5.7%
Burns and accidents	11,931	5.2%
Rheumatic fever	8,753	3.8%
Eye conditions	6,675	2.9%
Epilepsy and other diseases of the nervous system	3,365	1.5%

The remainder includes tuberculosis of bones and joints, birth injuries, and miscellaneous conditions. While orthopedic conditions predominate, there has been a steady gain in other kinds of handicapping conditions accepted for care by an increasing number of states. Today the states which limit their service to children with orthopedic conditions are a small minority.

Despite the great progress that has been made, however, it is apparent from these statistics that we still have a considerable way to go in meeting the needs of handicapped children. The general trend seems to be toward the inclusion of children with any type of long term handicapping or potentially handicapping condition. In fact, many state agencies define crippled children as those with physical conditions which may interfere with their growth and development.

As the state programs have broadened, there has developed increasing recognition that to be successful these services must be child-centered rather than organ-centered. Thus we see today that the state agencies have been moving toward a concept of crippled children's services as pediatric programs for children who are in need of long term care. This concept is a very important one, since our interest in the child's handicap should be secondary to our concern for the child as an individual who is growing physically, socially, and emotionally. We feel,

therefore, that the handicapped child should be under the general health and medical supervision of a pediatrician. The problems posed by crippling are often long in duration and they affect the child's growth and development. How adequately the child is cared for, how much insight our professional workers have into the psychological as well as the physical complexities of long term illness, will often make the difference between the handicapped youth or child who has a healthy personality and one who is maladjusted and emotionally ill despite maximal physical restoration.

An understanding of the problems of long term illness serves to emphasize the importance of preventive services in a crippled children's program. Prevention in this situation means not only services to prevent the onset of crippling illness, but also services to mitigate crippling and to minimize emotional maladjustment and social disability.

For example, it is well known that epilepsy in a child constitutes a major tragedy for him all too frequently. His seizures too often result in his exclusion from school, rejection by his playmates, and inability to get a job. Yet with proper diagnosis and treatment, seizures in 80 per cent of the children can be brought under control. This is only the first step, however. Epilepsy need not cripple a child today, nor result in his being a social outcast if, in addition to treatment, community services also work to improve the public's understanding of the condition and encourage the schools to accept children whose seizures are under control. This calls for organized community action. It is not an easy task to overcome the prejudices and misunderstanding of many generations.

So far as hard of hearing children are concerned it is chiefly lack of sufficient personnel and facilities or adherence to an outmoded tradition that permits young children with serious hearing impairment to wait until six years of age, or the time of entering school, to begin speech and auditory training. The optimal time to begin helping such children is at two or three years, or even earlier, thereby taking advantage of the period in normal child growth when language development is at its peak. Care in the preschool years would enable many of these children to continue to live at home and attend day schools rather than live in the segregated environment of a residential institution.

The close relationship between special education and medical services for crippled children has been recognized for a long time. The 1930 White House Conference made the following recommendation:

> A State program for crippled children should be built upon the rights of individuals to an equality of opportunity, especially from the educational standpoint. Academic education and prevocational and vocational guidance and training adapted to crippled children should be available to them at all times in which they are physically able to receive the same regardless of the location of their residence. Physical care and education, designed to produce self-supporting and useful citizens should be carried on together.

The Children's Bureau has consistently supported this recommendation. The purpose of our health and medical services for crippled children is to help them to become contributing rather than dependent members of society. This objective cannot be achieved if they do not have educational opportunities which should go hand in hand with their medical care. Some children are in hospitals or convalescent homes or cared for in their own homes for

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many months with little opportunity to maintain their ties with school work. Many children, such as the visually handicapped and the hard of hearing, can attend regular schools if the curriculum is adjusted to their needs. Others are unable to attend school unless provision is made for their transportation. Obstacles to providing education for exceptional children represent a tremendous waste in human resources.

There have been many important gains in the care and education of handicapped children. There are, however, great variations among the states in providing opportunities for them. We would like to see every state have a well organized program for exceptional children that includes medical care, social services, special education, and vocational guidance and rehabilitation. Such services are needed if these children are to be helped to develop to their fullest physical, social, and mental capacities.

Workshop Hints on Chapter Organization

SOME questions that occur to all chapter officers are detailed with their answers, in a mimeographed outline of the Boston ICEC Workshop for Chapter Officers. They do not constitute official action on the part of the delegate assembly or other governing body of the Council. However, they do represent the best thinking of a group of people giving considerable time and attention to desirable chapter programs. A few salient points are summarized here.

Organization of Program. More than four meetings should be held a year. Professional, social, and business features of the meetings can be combined through such devices as pre-program dinners or teas and entertainments, and clearing most details through executive committee meetings. Fall and spring membership roundups, and at least one preconvention meeting for election of delegates and officers should be held. For spread of interest, some, or all meetings should be open to the public.

Programs can be announced to the membership by yearbook, postcard, announcement in school calendar, or circular letter from the central special education office. In addition, it should be one committee's duty to telephone members and remind them shortly before meeting date. Newspaper, TV, and radio announcements also bring better attendance.

The pattern of programs can be as flexible as the chapter desires. Some are arranged by the year on the study-group principle, some by semester for inservice training; or separate topics for each meeting can be selected from a survey of member interests. Presentation can be made by speakers, discussion panels, films, demonstrations, field trips, and even through social events.

State Organization. All members of the locals should be members of a state federation. Such an organization brings together chapters or individuals who work in similar legal patterns, and permits better organization for work with the state education association or for state legislation, than is possible by individuals or single chapters.

Hazards to avoid in state organization are over-organization and the danger of forgetting the larger ICEC picture in the state picture. If there

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is no state organization as yet, a statewide conference should be held to organize one. Each local group and each interest group should be represented on the state board. Relationship between state and ICEC should be plainly defined.

Membership. The entire group agreed that all educators should be admitted to ICEC membership, and that community leaders, especially doctors, should be admitted. As to admitting other categories of persons interested in exceptional children there was substantial disagreement—for instance although a majority believed anyone interested or willing to serve should be admitted, when it came to offering group or individual membership to parents, only one third approved. Two thirds disapproved.

Selection of Officers. Officers should be active chapter members with broad professional background, who are chosen by the whole chapter. Personal qualities, however, are more important than professional level. Term of office should be limited, and provision for continuity of office assured by previous, or later, service on the advisory board or executive committee. The best method for finding good officers is to encourage participation of all members in active committee work, and to arrange for spread of fields of interest on the executive committee. Long range planning makes interested leadership and membership possible.

The nominating committee should be chosen by the whole membership early in the fall, and membership and department heads should be asked for suggestions for the slate of officers. Officers must be selected before the ICEC convention.

Finance. Every chapter should make a budget to cover such matters as sending delegates to the convention, postage, rental of meeting rooms, and special projects for the year. More than 30 suggestions were made on money-raising methods. Some of them were: charging fees for inservice training courses, joint chapter social functions, enlisting aid from service clubs, and charging admission for talks by nationally famous speakers.

Projects. In some detail, the workshop dealt with projects a chapter can undertake in connection with special days and weeks, demonstration programs for local organizations, joint area meetings, exhibits, newspaper publicity, and radio and television possibilities.

Teacher recruitment can be encouraged by projects in connection with Future Teachers of America, college career days, provision of teacher training scholarships, and so on.

Suggestions for informing the public on special education purposes, programs, and needs were many and varied. They ranged from extending membership to representatives of other community associations to such projects as supplying bibliographies and special materials for libraries and organizing surveys to determine community special education needs.

H. PAT WARDLAW, "I think it is a shame and a disgrace that in most states we have had to set up a program of subsidies for special education to encourage local school administrators to fulfill an obligation which has always been theirs. This program should be part of the total school program, and each school district ought to accept its own responsibility in educating all the children."—*ICEC-AASA meeting.*

OUT OF THE CLASSROOM

Jo Kelly and Marguerite Rapson

THE "SPINNER" COMES INTO MANY USES

The number spinner, which may be secured in many commercial games, comes into its own in the speech correction class. Prepare cards for children who can read containing word lists, sentences, jingles, and nursery rhymes. Place these cards in six or eight piles, depending on the number of cards and the highest number on the spinner. As each child spins, he removes the top card from the pile corresponding to the number he has received on the spinner. If he can read his card with no enunciation errors, he keeps the card. The person with the most cards at the end of the stated time wins.—MILTON EASTMAN, *Peoria Schools, Peoria, Ill.*

HOMEBOUND QUARTERLY

As a means for providing homebound pupils with an opportunity for self-expression, *Home Bound News* was published.

Students being taught by home instructional service, or by the two-way electrical equipment, comprise the staff; editor, assistant editor, and reporters.

The general outline of the small quarterly is much the same as that of the usual school paper; containing editorials, book reviews, news items, news quotes, from time to time a discussion of a boy's or girl's hobby or hobbies, original verses, selected poems, jokes and riddles, and as a closing, a note of thanks by the editor for cooperation on the part of her staff, and for favorable comments received from other publications and school personnel. Appropriate covering and mimeographing is done by the clerical staff of the special education department.

Copies of *Home Bound News* are sent to both high school and grade schools, in order that classroom teachers know of the interests and achievements of homebound boys and girls. This also helps to keep these children in closer touch with their respective schools.—MARY C. PLAMADORE, *home instructor, special education department, Cedar Rapids Public Schools, Cedar Rapids, Iowa.*

MUSIC FOR THE SOCIALLY MALADJUSTED

The Moore School for Boys is an observational institution established by the Detroit Board of Education to treat the socially maladjusted boy. Music is an important part of the curriculum. There is a 30 voice choir, an instrumental band, and a rhythm band.

The rhythm band has appeared on television. The following article by William Noble appeared in the *Detroit News* on Feb. 6, 1953.

The joint starts jumping when the Moore School rhythm band starts banging out jive melodies on the strangest assortment of instruments since the lute. The bass fiddle is a five gallon can with string and stick attached. The jungle drums are rusty peach cans with inner tubes stretched across their

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tops, the old pop bottles produce haunting tunes. The band is a potent weapon in the fight on juvenile delinquency.

"When the boys find they can make music come out of a rusty can or an inner tube found in the alley, it changes them," says Edward Ervin instructor. "We no longer have to worry about them."

—EARL MAYREND, *principal, Moore School for Boys.*

A TELEPHONE SWITCHBOARD

An obsolete telephone switchboard is being used in El Monte, California, for the first time to provide cerebral palsied children with vitally-needed therapy.

The switchboard was reconditioned by Pacific Telephone Installer Dick Curtis of Arcadia on his own time. It is improving eye-hand coordination and speech for some 50 students of the Lexington School for Cerebral Palsied Children in the El Monte Public School District.

Principal Hans Mayr praised the switchboard installation. "Its purpose of motivating speech, eye-hand coordination and stimulating muscular activity is remarkable," he said.

Students using the switchboard are ages three to 20. They live in many parts of California's San Gabriel Valley, just east of Los Angeles.

The board has the normal number of switches, lights and jacks. Several children benefit from its use at one time through four connected telephone instruments.

Therapists Violet McCarty and Jean Dillon said the switchboard gives resistance as well as desirable finger, wrist and arm movements to the young students.—From THE PACIFIC TELEPHONE AND TELEGRAPH COMPANY, PUBLIC RELATIONS OFFICE, *711 S. Olive St., Los Angeles, Calif.*

A TEACHER MAKES SPEECH TIME CLOCKS

Every year I find myself confronted with the problem of getting the children scheduled for speech work to speech lessons on time. The classroom teacher is so busy she often forgets to send them, and the children do not always remember nor can all tell time. Drawing clocks on cardboard with the hands on their "speech time" and then taping these clocks to their classroom desks has been a big help. Needless to say the children love these timepieces.—MRS. ALICE BANTE, *Venice Public Schools, Venice, Ill.*

TEACHING BY TELEPHONE

(*Continued from page 104*)

The original manuscript was submitted to a list of several hundred educators, many of whom have worked with Teaching by Telephone, for editing and suggestions. A conscientious effort was made to embody *all* of their suggestions in this report, which we trust will serve as an effective, instructional handbook to assure proper use of this technique. We want to acknowledge their help and express our very deep gratitude for it. The experience of this survey led to the formation of an educational advisory committee of authorities in school administration and special education which will act as a guide in carrying on additional research and furthering a broader understanding and acceptance of the values and application of this method of educating homebound children.

I.C.E.C. FAMILY ALBUM

Ruth DuPuis
Oregon

T. Ernest Newland
Illinois

Mildred Walton
Michigan

John E. Taylor
Oregon

Melba M. Miller
California

Ruth DuPuis, ICEC membership chairman for Oregon, has travelled the state over to encourage the forming of ICEC chapters, four of which have joined the Council since last spring. She was Portland's delegate to the Omaha convention in 1952, and will be secretary of the chapter for 1953-54.

John E. Taylor is assistant director of special education in Oregon state department of education and director of Oregon's speech and hearing program. As an active ICEC member, he serves on the credentials committee, and is an associate editor of *Exceptional Children.*

T. Ernest Newland, professor of education, University of Illinois, was one of the prime movers in organizing the Illinois Association for the Education of Exceptional Children (the ICEC state federation) and served as its president last year. He is an associate editor of *Exceptional Children* and editor of the series on clinical services now appearing in the Journal.

Mildred Walton, director of Michigan· Univ. Hospital School, chairs ICEC's committee on the hospitalized child. As chairman, she has recently conducted a survey of 559 hospitals throughout the United States to determine the number and nature of educational and recreational programs for hospitalized children. She is past president of her local ICEC chapter, and has been an ICEC member for 10 years.

Melba M. Miller, superintendent of the School for Cerebral Palsied Children, Southern California, is the Council's new recording secretary. She is also an associate editor of *Exceptional Children.* Since 1939, Miss Miller has been an ICEC member. In 1939, she acted as a member of the program committee for the San Francisco convention.

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Jane E. Dolphin

Compiled with the Assistance of the Library, National Society for Crippled Children and Adults, Chicago.

NEW BOOKS BRIEFLY NOTED

JENKS, WILLIAM F., ed. *Special education of the exceptional child (Proceedings of the workshop on special education of the exceptional child, conducted at the Catholic University of America from June 13th to June 24th, 1952).* 1953. 333 p. Catholic Univ. of America Pr., Washington, D C. $2.75, cloth; $2, paper.

This volume contains the papers delivered at the morning sessions of the workshop for Catholic educators, and the brief reports of the four seminar groups which worked in the afternoons. The lectures covered the various types of handicapped children and such other subjects as social and emotional problems, remedial reading and tests and measurements. Bibliography.

KARMEL, ILONA. *Stephania.* 1953. 375 p. Houghton Mifflin Co., Boston, Mass. $3.75.

For a year a room in a Swedish hospital is occupied by three women—Thura, a 16-year old completely immobilized by polio, Froken Nilson, an incurably romantic spinster from the provinces whose compulsive eating complictaes the healing of a broken leg, and Stephania, a Polish refugee whose hunchback had developed untreated during the Nazi regime. Against the routine and psychology of hospital life, the influence of Stephania on her wardmates, and theirs on her, slowly unfolds; while none is physically rehabilitated as she had hoped, all were able to face the world of reality with more maturity.

PAINE, IRMA LITTLER. *Art aids for elementary teaching; a handbook.* 1953. 88p., illus. Spiral binding. Burgess Publishing Co., Minneapolis, Minn. $2.25.

Theoretical and practical information on the objectives of art education, teaching art appreciation, the elements and principles of design, media for a variety of art processes, and chapters on construction and handwork and the lettering of posters are included in this handbook. Methods suggested have been used successfully in the field of school art education.

POLLOCK, MORRIS P. *New hope for the retarded; enriching the lives of exceptional children,* by Morris P. and Miriam Pollock. 1953. 176 p., illus. Porter Sargent, Boston, Mass. $4.50.

Written as a textbook for students of child psychology, as a source of fresh material for special teachers, and as a guide to parents, this book offers a variety of educational aids for the curriculum. A chapter is devoted to developing speech in the child who does not talk. Others give suggestions on planning parties, on handicraft projects, and on educational devices to develop coordination and stimulate thinking and use of judgment.

SARASON, SEYMOUR B. *Psychological problems in mental deficiency; 2d ed.* 1953. 402 p., illus. Harper & Bros., New York, New York. $5.

Since the first edition appeared in 1949, this book has served as a standard text on current psychological trends and practices. The second edition is unchanged except for the addition of three chapters on the interpretation of mental deficiency to parents, the question of institutionalization faced by parents, and the problem of adequate training in parent relations that professional personnel fail to receive.

PERIODICAL ARTICLES AND PAMPHLETS

Auditory Impairments

AMERICAN ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY. "Symposium: Conservation of hearing." Trans., Am. Acad. of Ophthalmology and Otolaryngology, May-June 1953. 57:3:334-355.

Contents: How to develop a hearing con-

servation program, Lydia Newton.-How to organize your state medical association for a conservation of hearing program, Joseph M. Kinkade.-Description of the education follow-up in a conservation of hearing program, A. E. Cruthirds. "I scarce was sure I heard you," Edmund P. Fowler, Sr.

GLOWATSKY, EDWARD. "The verbal element in the intelligence scores of congenitally deaf and hard of hearing children." *Am. Annals of the Deaf.* May 1953. 98:3:328-335.

The Wechsler, the Grace Arthur, Form II, and the Goodenough "Draw-A-Man" tests were administered to 24 deaf and hard of hearing children at the New Mexico School for the Deaf. Conclusions drawn from the experiment are presented.

KITINOJA, PHYLLIS. "Creative art and the deaf child." *Am. Annals of the Deaf.* May 1953. 98:3:312-317, 320-332.

Techniques stimulating creative expression in art are discussed. Various media are recommended for different stages of art development.

OLERON, PIERRE. "Conceptual thinking of the deaf." *Am. Annals of the Deaf.* May 1953. 98:3:304-310.

Sorting tests indicated that the difficulties of the deaf come from their attachment to observed data and from the nonsubordination of these data to abstract conceptual conditions. This is the mark of a retarded development rather than of a real incapacity.

RICHMOND, JULIUS B. "A hearing test for newborn infants," by Julius B. Richmond, Herbert J. Grossman, and Seymour L. Lustman. *Pediatrics.* June 1953. 11:6:634-638.

A simple, readily reproducible test of gross hearing in the newborn infant is presented.

Epilepsy

LENNOX, WILLIAM G. "The sociopsychological treatment of epilepsy," by William G. Lennox and Charles H. Markham. *J. Am. Med. Assn.* Aug. 29, 1953. 152:18:1690-1694.

The authors discuss public misunderstanding of epilepsy, problems of marriage and employment, and the physician's responsibility in treating emotional and social handicaps.

Orthopedic and Neurological Impairments

BERKO, MARTIN J. "Some factors in the mental evaluation of cerebral palsied children." *Cerebral Palsy Rev.* May-June 1953. 14:5 and 6:6, 11, 15.

The writer suggests approaches and procedures for more properly evaluating mental age through use of standardized tests.

BICE, HARRY V. "Observations on teaching the cerebral palsied." *Cerebral Palsy Rev.* May-June 1953. 14:5 and 6:7, 12-14.

Educational and emotional problems are reviewed for the teacher who has had limited experience with this group.

DEAVER, GEORGE G. "Home care for the child with spina bifida," by George G. Deaver and Jean McCarthy. *Nursing Outlook.* June 1953. 3 p.

The public health nurse and her role in parent education and counseling are discussed. A program of home care for the child at various age levels is included.

KESSLER INSTITUTE FOR REHABILITATION. *Clinic on congenital amputations (Proceedings of the . . . , Vol. 1, no. 2, 1953).* 1953. 35 p. The Institute, West Orange, N.J.

Contents: The experimental investigation of congenital deformities, L. C. Dunn.-Reproductive characteristics of the parents of congenitally malformed children, Douglas P. Murphy.-The role of environment in the production of certain congenital defects as illustrated by the postrubella syndrome, Robert F. Korns.-Pediatric aspects of congenital amputations, Harrold A. Murray.-The management of congenital amputations, Henry H. Kessler.

WALPOLE, BENJAMIN M., JR. "ABC's for teachers of the cerebral palsied." *Cerebral Palsy Rev.* July 1953. 14:7:9.

The cerebral palsied child presents the same problems as the normal child, plus many stemming from his physical limitations and related to his social and emotional development. The writer points out briefly the nature of these problems and ways of solving them.

WHITEHOUSE, FREDERICK A. "Cerebral palsy and vocational habilitation." *Cerebral Palsy Rev.* July 1953. 14:7:7, 11, 15.

Results of a study at the Institute for Crippled and Disabled, New York City, indicate that vocational rehabilitation for the cerebral palsied compares unfavorably with those handicapped by poliomyelitis. Progress in increased services, legislation, special education, research, and public education will improve vocational prospects.

Retarded Mental Development

BERGMAN, MURRAY "The value of the Thematic Apperception Test in mental deficiency," by Murray Bergman and Louise A. Fisher. *Psychiatric Quarterly Supp.* Part I, 1953. 27:22-42.

Administered to 50 institutionalized mental defectives with atypical mental reactions the

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test proved to be successful in overcoming resistances and in establishing the "personality profile."

BENOIT, E. PAUL. "More fun for institutionalized retarded children." *Am. J. Mental Deficiency.* July 1953. 58:1:93-107.

Following a brief analysis of the circumstances to be faced by an institutional recreation leader, the author describes, as a demonstration project, play activities that were incorporated in a birthday party for a group of boys.

CASSEL, MARGARET E. "Comparison of three etiological groups of mentally retarded children on the Vineland Social Maturity Scale," by Margaret E. Cassel and Margaret M. Riggs. *Am. J. Mental Deficiency.* July 1953. 58:1:162-169.

This paper is a report of a study of 60 subjects, 20 each from 3 etiological groups—familial, organic, and "unexplained." Familial subjects are relatively competent in all areas and organics are not. The unexplained cases have a well defined pattern of competence in some areas and incompetence in others.

CASSEL, MARGARET E. "A note on exogenous factors in the case histories of mongoloid individuals." *Training School Bul.* June 1953. 50:4:65-70.

Case histories indicate that mongoloids cannot be considered as a homogenous group free from organic pathologies or conditions which are of etiologic significance in other types of defective children.

DELP, HAROLD A. "A follow-up of 84 public school special class pupils with I.Q.'s below 50," by Harold A. Delp and Marcella Lorenz. *Am. J. Mental Deficiency.* July 1953. 58:1:175-182.

By compiling and arranging the facts in different areas, a study was developed to show in a more specific manner some of the probable outcomes of a public school training program for so-called non-educable children.

LEVINSON, ABRAHAM. "Mental retardation in children," by Abraham Levinson and Charles Goldenberg. *J. Am. Med. Assn.* June 27, 1953. 152:9:781-787.

A report of a study of 150 cases of mental retardation at the clinic for mentally retarded children of the Dr. Julian D. Levinson Research Foundation, Chicago.

MCLEAN, MARY CANNON. "Easing the load of the limited; a practical approach to public relations for special education." *Am. J. Mental Deficiency.* July 1953. 58:1:21-38.

This article is comprised primarily of a script and 15 illustrations of glass slides that "were made to familiarize parents and other groups with the problem of special education in a New England city."

MORGAN, LEONARD, JR. "The chaplain and the mental defective." *Am. J. Mental Deficiency.* July 1953. 58:1:78-81.

The three types of service the chaplain at the Kentucky Training Home renders are (a) that of minister, (b) that of counselor and guide, and (c) that of stimulating public relations activities with other clergymen and groups.

STACEY, CHALMERS L. "The color preferences of a group of subnormals," by Chalmers L. Stacey and William F. Reynolds. *Training School Bul.* June 1953. 50:4:59-64.

Report of a color preference test constructed and adimnistered to 134 subnormal boys and 195 subnormal girls at a state school, suggested that results be applied to academic and vocational classes and to play and classroom materials.

TIZARD, J. "The effects of different types of supervision on the behavior of mental defectives in a sheltered workshop." *Am. J. Mental Deficiency.* July 1953. 58:1:143-161.

Findings of an experiment with 36 high-grade defective boys indicate that there was little difference between the scores of the groups under strict and friendly supervision, except for individual boys. Few were able to work well under laissez-faire supervision.

WHITNEY, E. ARTHUR. "Mental deficiency 1952." *Am. J. Mental Deficiency.* July 1953. 58:1:1-12.

A review of the literature during 1952 on research covered in relation to cerebral palsy, Mongolism, childhood schizophrenia, aphasia, autism, and delayed respiration at birth.

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Speech Impairments

CHICAGO PUBLIC SCHOOLS. *Speech correction techniques, materials, references.* 1952. 71 p., illus. Mimeo. Chicago Public Schools, 228 N. LaSalle St., Chicago, Ill.

Useful materials and activities are listed and described. Original activities contributed by members of the division staff and found to be effective are described. Bibliographies.

FOOTE, ROBERT M. "Toward better speech and hearing; Tennessee children are tested by State Crippled Children's Service," by Robert M. Foote and Sylvia Stecher. *The Child.* June-July 1953. 17:10:154-157.

Tennessee's over-all program to find, treat,

and rehabilitate children and adults handicapped by speech and hearing defects is discussed briefly.

LORE, JAMES I., JR. "Speech and hearing therapy in Delaware." *Del. School J.* Apr. 1953. 18:4:8, 20.

Delaware's state-wide speech and hearing program is described.

"PERSONALITY DEVELOPMENT AND SPEECH THERAPY." *Western Speech.* Jan. 1953. 17:5-17.

A condensation of papers presented at the convention of the American Speech and Hearing Association, Dec. 1951, by Gordon M. Low, chairman, Boyd V. Sheets, Paul H. Ptacek, and Jane Beasley.

SCHLANGER, BERNARD B. "Speech measurements of institutionalized mentally handicapped children." *Am. J. Mental Deficiency.* July 1953. 58:1:114-122.

"Coefficients of correlation between the test scores and the MA score were higher than the relationship between the same scores and the C.A. The highly significant relationships between the scores suggests the interdependence of the measures used."

Visual Impairments

ABEL, GEORGIA LEE. *Suggestions, resources and equipment for teachers educating blind with seeing children in public and private schools.* 1953. 33pp. Mimeo. American Foundation for the Blind, 15 W. 16th St., New York 11, N.Y. $1.

This bulletin for public school teachers lists resources and equipment and presents statements of philosophy concerning the program, various subject matter areas, and the actual use of types of equipment.

AMERICAN FOUNDATION FOR THE BLIND. *Hobbies of blind adults,* by Charles G. Ritter. *No. 8, Educational ser.*) 1953. 52 p. American Foundation for the Blind, 15 W. 16th St., New York 11, N.Y. 45c.

Handicraft and general hobbies, as well as social activities, for the blind adult are described, and an extensive list of addresses is included.

AMERICAN FOUNDATION FOR THE BLIND. *Training facilities for the preparation of teachers of blind children in the United States.* 1953. 38 p. American Foundation for the Blind, 15 W 16th St., New York 11, N.Y. 25c.

A review of the symposium at the meeting of the International Council for Exceptional Children, Omaha, 1952.

DAVENS, EDWARD. "Health department responsibility for sight conservation." *Sight-Saving Rev.* Summer 1953. 23:2:80-85.

Visual impairment is identified as a public health problem of top priority. The author explains why public health methods and the services of state and local health departments are essential to a solution of the problem.

NATIONAL SOCIETY FOR THE PREVENTION OF BLINDNESS. "Helping the partially seeeing child in the regular classroom." *Sight-Saving Rev.* Summer 1953. 23:2:95-99. Reprint. 5c.

Material in this article is from a pamphlet developed to meet the needs of teachers who do not have specialized services available for helping the partially seeing child in the regular classroom situation.

US CHILDREN'S BUREAU. *The preschool child who is blind. (Children's Bur. folder no. 29-1953)* 1953. 23 p. US Superintendent of Documents, Washington 25, D. C. 10c.

A leaflet, the latest in the Bureau's series designed to help parents who have a child with a handicapping condition.

General

AMERICAN ACADEMY OF PEDIATRICS. "Problems in child psychiatry; a round table discussion." Leo Kanner, M.D., chairman. *Pediatrics.* Apr. 1953. 11:4:393-404.

A discussion of the need for closer relationships between the child psychologist and the pediatrician and orientation of the pediatrician in the problems and methods of child psychiatry.

BROADHURST, R. G. "Art and crafts in special schools." *Special Schools J.* Apr. 1953. 42:2:5-8.

Offers suggestions on adapting art and constructive craft projects to special school curricula, relating them to other subjects to create interest in various fields.

Other articles in the same issue: Drama in special schools, by P. Slade, p. 9-13; Craftwork, by Benjamin T. Richards, p. 13-24.

BROWN, RICHARD L. "Swimming activity for the handicapped." *J. Am. Assn. Health, Physical Education and Recreation.* Apr. 1953. 24:4:14-15, 51.

A discussion of swimming as an activity

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for the handicapped, objectives and special skills to be taught, ways of modifying strokes, and a brief outline for setting up a community program.

CHILD STUDY ASSOCIATION OF AMERICA. *Parent group education and leadership training; three reports.* Rev. ed. 1953. 21 p. Child Study Association of America, 132 E. 74th St., New York 21, N.Y. 25c.

Contents: Parent discussion groups, their role in parent education, Aline B. Auerbach; The technique of parent group education, some basic concepts, a summary of material presented by Peter B. Neubauer in a training program for parent group leaders; Training for parent group leadership, Aline B. Auerbach and Marion F. Langer.

FALKNER, FRANK. *The convalescent child.* 1952. 55 p., illus. University of Liverpool, Liverpool, England.

A study of the theoretical and practical considerations of convalescent care, carried out between Nov. 1948, and Apr. 1951, in the British Isles. The study has sections on the psychology of the convalescent child, his education, climatic considerations, the economic aspect of providing care, and recommendations suggested for improving services or providing non-existent ones. Problems connected with home care of convalescents, foster care, special day-school care, longterm convalescent children's homes, various age groups, visiting, and entertainment are discussed briefly.

GRASSI, JOSEPH R. "School psychological clinics; part II: New developments and results." *N. C. Med. J.* May 1953. 14:5: 184-194.

A well organized, highly coordinated school psychological program, including the services of a variety of specialists is presented.

GREAT BRITAIN. MINISTRY OF EDUCATION. *The health of the school child; report of the chief medical officer of the . . . for the years 1950 and 1951.* 1952. 144 p., illus., tables. Published by H. M. Stationery Office, London, and available from British Information Service, 30 Rockefeller Plaza, New York 20, N. Y., at $1.25 a copy.

Covers school health services in England, special education for various handicapped groups, and statistical information on special schools, incidence of various diseases, treatments given for specific defects, and mortality.

US PUBLIC HEALTH SERVICE. *Identification of maladjusted school children; a comparison of three methods of screening,* by Charles A. Ullmann. 1952. 41 p., tabs. (*Public Health Monograph no. 7. Public Service publication no. 211.*) Superintendent of Documents, Washington 25, D. C. 25c.

A report on a public health program in Prince Georges County, Md., which surveyed the nature and extent of the mental health problem presented by a group of ninth grade children in the public school system, and tested methods for identifying individuals needing psychological assistance.

WALTON, ELOISE. *Let's work together in community service.* 1953. 28 p., illus. (*Public Affairs pamphlet no. 194*) Public Affairs Committee, 22 East 28th St., New York 16, N.Y. 25c.

A summary of *Community Planning for Human Services,* by Bradley Buell and associates, telling the story of a family whose multiple problems called for services from 16 different agencies and pointing up the need for more integration of services and cooperation among agencies.

DATES TO REMEMBER

Dec. 27-30	National Science Teachers Assn, NEA, Boston
Dec. 27-30	**ICEC Regional, Houston, Texas**
Dec. 28-30	National Council of Teachers of Mathematics, NEA, Los Angeles
Feb. 11-13	Dept. of Elementary School Principals, NEA, Atlantic City
Feb. 11-13	Am. Assn of Colleges for Teacher Education, NEA, Chicago
FEB. 15	AM. ASSN FOR GIFTED CHILEREN, INC. ATLANTIC CITY
Feb. 15-16	**AASA-ICEC Joint Meetings at AASA convention, Atlantic City**
Feb. 15-18	Dept. of Rural Education, NEA, Atlantic City
Feb. 17	**ICEC meeting at AASA convention, Atlantic City**
MAR. 10	AMERICAN ASSN OF PSYCHIATRIC CLINICS FOR CHILDREN
Mar. 10-12	NATIONAL SOCIETY FOR THE PREVENTION OF BLINDNESS, ST, LOUIS
APR. 11-15	AMERICAN PERSONNEL AND GUIDANCE ASSN, BUFFALO, N.Y.
Apr. 12-13	**ICEC sessions at the Second Regional Instructional Conference, Minneapolis**
APR. 19-23	CONFERENCE OF EXECUTIVES OF AMERICAN SCHOOLS FOR THE DEAF, SCHOOL FOR THE DEAF, SANTA FE, N.M.
Apr. 27-May 1	**International Council for Exceptional Children, International convention, Cincinnati**

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